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Stoli on the Rocks: Why States Should Eliminate the Abusive Practice of Stranger-Owned Life Insurance

Eryn Mathews

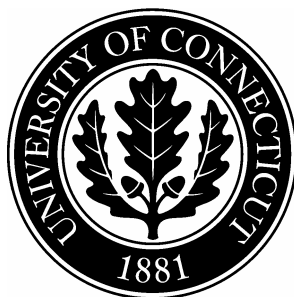
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SOCIAL SOLIDARITY AND PERSONAL RESPONSIBILITY IN HEALTH REFORM

Wendy K. Mariner

In the United States, calls to expand access to health *care*, when not simply ignored, typically result in bills or legislation to reform health *insurance*. We are in the midst of just such a cycle today. Several states have adopted reform laws to make insurance available to most of their residents.¹ Presidential candidates are offering their own proposals for the nation's health care system.² Former Treasury Secretary Paul O'Neill even declared that health care should be a right, adding that wealthier people should help pay for those who will never be able to afford their own care.³ Most Americans cannot afford to pay for more than minor medical procedures out of their own pockets. Insurance is the vehicle that finances the rest.⁴ Thus, insurance has come to stand for health care.⁵

1. See, e.g., An Act to Provide Affordable Health Insurance to Small Businesses and Individuals and to Control Health Care Costs, 2003 Me. Laws 469 (codified in scattered sections of ME. REV. STAT. ANN. 2, 5, 22, and 24); An Act Promoting Access to Affordable, Quality, Accountable Health Care, 2006 Mass. Acts 58 (codified as amended in scattered sections of MASS. GEN. LAWS 6A, 10, 17, 26, 29, 32, 62, 111, 111M, 118E, 118G, 118H, 149, 151F, 175, 176A, 176B, 176G, 176J, 176M, 176N, and 176Q.); Act Relating to Health Care Affordability for Vermonters, 2006 Vt. Acts & Resolves 191 (codified as amended in scattered sections of VT. STAT. ANN. 2, 3, 8, 18, 32, and 33); Act Relating to Catamount Health 2006 Vt. Acts & Resolves 190 (amending 2006 Vt. Acts & Resolves 191). See John McDonough et al., *The Third Wave of Massachusetts Health Care Access Reform*, 25 HEALTH AFF., Sept. 14, 2006, at w420, <http://content.healthaffairs.org/cgi/reprint/25/6/w420> (describing the Massachusetts law and its development); State of Maine, Dirigo Health – Working for Maine, <http://www.dirigohealth.maine.gov> (describing Maine's program). See generally Alice Burton et al., *State Strategies to Expand Health Insurance Coverage: Trends and Lessons for Policymakers* (2007), available at http://www.cmwf.org/publications/publications_show.htm?doc_id=461903.

2. For summaries of the candidates' proposals, see Farhana Hossain, *The Presidential Candidates on Health Care*, N.Y. TIMES, http://www.nytimes.com/ref/us/politics/HEALTH_POSITIONS_2.html.

3. David Wenner, O'Neill Advocates Health Care as a Right, THE PATRIOT-NEWS April 19, 2007, available at <http://www.pennlive.com/printer/printer.ssf?base/business/117694502191220.xml&coll=1>.

4. See generally, INSTITUTE OF MEDICINE, COMMITTEE ON THE CONSEQUENCES OF UNINSURANCE, COVERAGE MATTERS: INSURANCE AND HEALTH CARE (2001). Here I use the concept of insurance rather liberally to include government health benefit programs, such as Medicare, 42 U.S.C. §§ 1395 et seq., Medicaid, 42 U.S.C. §§ 1396 et seq., and the State

Yet buying health insurance is not the same thing as buying health care. Conflating the two can exacerbate disagreements about the responsibilities of government, business, and individuals for health and health care.⁶ Health reform proposals reflect different philosophies about who should be responsible for certain health conditions—society at large, employers, or the individual herself. Current health insurance reform proposals borrow from both camps, combining provisions promoting social solidarity with provisions based on actuarial fairness.

This essay argues that amalgamating reforms that serve inconsistent goals can perpetuate, rather than resolve, conflict. Part I suggests that joining social insurance with commercial indemnity insurance provisions forges a contract for traditional indemnity coverage plus discretionary personal services—an “insurance + services” contract—which pulls the system in opposite directions, forcing insurers to act as both insurers and service providers. Part II examines a recent example of the service side of this insurance + services contract—coverage of so-called “wellness programs,” which offer rewards for meeting specific standards of behavior. Often justified on grounds of actuarial fairness, they foster the idea that certain health conditions are matters of personal responsibility. Yet there has been virtually no discussion of what principles ought to govern the choice of conditions targeted by wellness programs. Experience to date suggests that such programs are likely to disadvantage those most in need of social assistance.

I conclude that the use of commercial insurance to provide access to care encourages reforms based on actuarial fairness instead of social solidarity. In the context of rising health care costs, the renewed emphasis on personal responsibility for health may unravel the social solidarity that

Children’s Health Insurance Program (SCHIP), 42 U.S.C. §§ 1397aa et seq., which also finance care.

5. Deborah Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity*, 6 CONN. INS. L. J. 11, 34 (1999/2000).

6. See, e.g., ALAIN C. ENTHOVEN, *HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COST OF MEDICAL CARE* (1980) (proposing competing health maintenance organizations); REGINA HERZLINGER, *WHO KILLED HEALTH CARE?* (2007) (arguing for a consumer-oriented system, with mandatory health insurance for all, subsidies for low-income people, and consumers choosing private plans with better information); MICHAEL E. PORTER & ELIZABETH OLMSTED TEISBERG, *REDEFINING HEALTH CARE* (2006) (arguing for value-based competition); JULIUS B. RICHMOND & RASHI FEIN, *THE HEALTH CARE MESS: HOW WE GOT INTO IT AND WHAT IT WILL TAKE TO GET OUT* (2005) (arguing for gradually expanding Medicare eligibility as a second best but politically feasible approach); Paul M. Ellwood et al., *The Jackson Hole Initiative for a Twenty-First Century American Health Care System*, 1 HEALTH ECON. 158 (1992).

prompted reform in the first place, especially for certain disfavored conditions or groups.⁷ These reforms may return us to the days before health insurance, and have the potential to undermine social solidarity beyond the insurance sphere.

I. SOCIAL SOLIDARITY AND PERSONAL RESPONSIBILITY IN HEALTH INSURANCE

When Senator Ron Wyden (D-OR) proposed federal legislation to cover all Americans with insurance in December 2006, he was hoping to break “60 years of gridlock on a desperately needed overhaul of the nation’s health care system.”⁸ Like several recent state reforms, his proposal offered both universal coverage and more personal responsibility in making health care choices.⁹ Yet, without greater clarity about whether insurance should reflect social solidarity or personal responsibility, or which health conditions deserve social insurance coverage and which do not, gridlock is likely to continue.¹⁰

Underlying much of the political disagreement are very different views about the nature of health care. At one end of a wide spectrum is the view

7. Stone, *supra* note 5 at 46 (“Insurance is a social institution that helps define norms and values in political culture, and ultimately shapes how citizens think about issues of membership, community, responsibility, and moral obligation.”). See Tom Baker, *Risk, Insurance, and the Social Construction of Responsibility*, EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY 27 (Tom Baker & Jonathan Simon eds. 2002) (how insurance reflects and influences cultural norms of accountability).

8. Press Release, Senator Ron Wyden, Wyden Proposes Historic New Health Care Plan (Dec. 13, 2006), *available at* http://wyden.senate.gov/media/2006/12132006_Healthy_Americans_Act.htm (announcing proposal of The Healthy Americans Act).

9. News Release, Senator Ron Wyden, Wyden Leads Federal Debate on Health Care Reform (Jan. 16, 2007), *available at* http://wyden.senate.gov/media/speeches/2007/01162007_Healthy_Americans_Act.html.

10. For a selection of explanations why the United States has never adopted a system for universal access to health care, much less national health insurance, *see, e.g.*, JACOB HACKER, THE DIVIDED WELFARE STATE (2002); JACOB S. HACKER, THE ROAD TO NOWHERE: THE GENESIS OF PRESIDENT CLINTON’S PLAN FOR HEALTH SECURITY (1997); DAVID MECHANIC, THE TRUTH ABOUT HEALTH CARE: WHY HEALTH REFORM IS NOT WORKING IN AMERICA (2006); JILL QUADAGNO, ONE NATION, UNINSURED: WHY THE U.S. HAS NO NATIONAL HEALTH INSURANCE (2005); JULIUS B. RICHMOND & RASHI FEIN, THE HEALTH CARE MESS: HOW WE GOT INTO IT AND WHAT IT WILL TAKE TO GET OUT (2005). *See also* Mark A. Peterson, *The Congressional Graveyard for Health Care Reform*, in HEALTHY, WEALTHY & FAIR: HEALTH CARE AND THE GOOD SOCIETY 205, 211-17 (James A. Morone & Lawrence R. Jacobs eds., 2005) (describing barriers to coalition building in Congress).

a person is (or ought to be) responsible for her own health and pay for her own medical care like other ordinary consumer goods.¹¹ At the other end are those who find health is somehow special so that society should be responsible for ensuring everyone access to care, regardless of ability to pay.¹² The difficulty of reconciling these opposing views of health care and the purpose and function of insurance has undoubtedly stymied agreement on reform.

Recent trends in health insurance in the United States reflect both of these competing views. On one hand, there are several signs that the country is moving toward universal health insurance coverage for reasons of social solidarity. Public opinion polls report that a large majority of Americans favor universal access to care.¹³ Health care is no longer affordable for most Americans without insurance.¹⁴ Employment-based health insurance covers a slowly declining proportion of nonelderly Americans.¹⁵ This decline has been offset by expansions in state Medicaid

11. See, e.g., RICHARD EPSTEIN, *MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE?* (1997) (arguing against redistribution of income and regulated markets); CLARK C. HAVIGHURST, *HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM* (1995); NATIONAL HEALTH INSURANCE: WHAT NOW? WHAT LATER? WHAT NEVER? (Mark V. Pauly ed. 1980) (analyzing the advantages and disadvantages of national health insurance).

12. See, e.g., NORMAN DANIELS, *JUST HEALTH CARE* (1985) (arguing that health care is special because it promotes equality of opportunity within the meaning of Rawls' theory of justice); INSTITUTE OF MEDICINE, COMMITTEE ON THE CONSEQUENCES OF UNINSURANCE, *INSURING AMERICA'S HEALTH* (2004); *Proposal of the Physicians' Working Group for Single-Payer National Health Insurance*, 290 JAMA 798 (2004).

13. See, e.g., CBS News & New York Times, Poll, U.S. Health Care Politics, Feb. 23-27, 2007, available at http://www.cbsnews.com/htdocs/CBSNews_polls/health_care.pdf (last visited March 2, 2007); Frank Newport, Prescription for Healing Healthcare from the People, The Gallup Poll, April 26, 2007, available at <http://www.galluppoll.com/content/Default.aspx?ci=27322&VERSION=p> (last visited March 2, 2008).

14. See Aaron Catlin et al., *National Health Spending in 2006: A Year of Change for Prescription Drugs*, 27 HEALTH AFF. 14 (Jan/Feb 2008) (reporting on public and private national expenditures, which total about \$2.1 trillion); A. Bruce Steinwald, Director, Health Care, U.S. Government Accountability Office, *Health Care Spending: Public Payers Face Burden of Entitlement Program Growth, While All Payers Face Rising Prices and Increasing Use of Services*, GAO-07-497T (Testimony Before the Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, Committee on Appropriations, House of Representatives, Feb. 15, 2007).

15. Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2007 Current Population Survey*, EBRI ISSUE BRIEF NO. 310 (Oct. 2007), available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_10-20073.pdf; Marsha

and SCHIP programs, but those public programs risk future cutbacks.¹⁶ Recognizing these trends, several states have adopted or are considering legislation to increase insurance coverage.¹⁷ But state level reforms are limited by ERISA preemption,¹⁸ and recent proposals for national reform at the federal level suggest that momentum for universal coverage is building.¹⁹ Even employers may support reforms that include universal coverage.²⁰

Gold, *Commercial Health Insurance: Smart or Simply Lucky?*, 25(6) HEALTH AFF. 1490, 1490 (2006).

16. See Paul Fronstin, *Uninsured Unchanged in 2004, But Employment-Based Health Coverage Declined*, 26 EBRI Notes 2, October 2005, available at www.ebri.org/pdf/notespdfs/EBRI_Notes_10-20051.pdf; Stephen Zuckerman, *Gains in Public Health Insurance Offset Reductions in Employer Coverage Among Adults*, 8 SNAPSHOTS III, Sept., 17, 2003, available at www.urban.org/UploadedPDF/310850_snapshots3_no8.pdf; Sara Rosenbaum, *The Proxy War—SCHIP and the Government's Role in Health Care Reform*, 358 NEW ENGL. J. MED. 869 (2008).

17. See *supra* note 1. See generally MARGARET TRINITY ET AL., STATE COVERAGE INITIATIVES, STATE OF THE STATES 2008, available at <http://www.statecoverage.net/pdf/StateofStates2008.pdf> (describing past and present state-based attempts at health care reform).

18. The Employee Retirement Income Security Act, 29 U.S.C. §§ 1001 et seq. Section 514(a), codified at 29 U.S.C. § 1144(a), generally preempts state laws that require private employers to provide health benefit plans for their employees, *Standard Oil Co. v. Agsalud*, 633 F.2d 760 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981) (holding that ERISA preempted Hawaii's Prepaid Health Care Act requiring employee benefit plans with prescribed health coverage), as well as reforms that alter the benefit structure or administration of such plans, *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983) (a state law relates to an ERISA plan "if it has a *connection with* or *reference to* such a plan."). Two recent lower court decisions found that ERISA preempts employer pay-or-play legislation in Maryland, *Retail Industry Leaders Association v. Fielder*, 475 F.3d 180 (4th Cir. 2007), and the city of San Francisco, *Golden Gate Restaurant Ass'n v. City & County of San Francisco*, No. C 06-06997 (N.D. Cal. Dec. 26, 2007), stay granted pending appeal, No. 07-17370 (9th Cir. Jan. 9, 2007). But see *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) (surcharges imposed on commercial health plans for hospital bills not preempted, because they do not preclude uniform benefits or administrative practices).

19. See INSTITUTE OF MEDICINE, *INSURING AMERICA'S HEALTH: PRINCIPLES AND RECOMMENDATIONS* (2004); and *supra* notes 3 and 9. But see Uwe Reinhardt, *Uninsured Americans and the new Democratic Congress*, 333 BRIT. MED. J. 1133, 1135 (2006) (arguing that the current "flurry of activity" will produce "big talk" but "little action").

20. See Robert S. Galvin & Suzanne Delbanco, *Between A Rock and A Hard Place: Understanding The Employer Mind-Set*, 25(6) HEALTH AFF. 1548 (Nov./Dec. 2006) (arguing that employers are looking for ways to get out of the health benefits business but reluctant to have government control costs); Jonathan Cohn, *What's the One Thing Big Business and the Left Have in Common?*, N.Y. TIMES MAGAZINE 45, April 1, 2007

At the same time, a competing trend has emerged favoring increased personal responsibility for health and health insurance. The beginning of the twenty-first century saw a return to more traditional indemnity health insurance following the late 1990's backlash against managed care.²¹ Although most health insurance plans still include procedures for managing care, most private insurance companies see their plans as a commercial insurance product covering specified losses, rather than a mechanism for financing universal access to care.²² Continuing health care cost increases also put pressure on insurers, government, and employers to reduce the need for care, tie premiums to claims experience, and shift more costs onto insureds.²³ Health savings accounts are popular among some employers, because they make employees responsible for a portion of their health care expenses.²⁴ A recent innovation, wellness coverage, offers discounted

(describing a business leader's cooperation to develop a federal reform bill); Jordan Rau, *Healthcare Reform's Unlikely Ally: Big Business*, L.A. TIMES, May 7, 2007 (describing a coalition of 26 large companies including insurers to advocate for universal health insurance in California). If true, this represents a change in business attitudes. See Jon R. Gabel, Anthony T. Lo Sasso & Thomas Rice, *Consumer-Driven Health Plans: Are They More Than Talk Now?* HEALTH AFF., Nov. 20, 2002, at w395 (survey results finding general lack of interest among insurers and employers in insurance divorced from employment), at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.239v1.pdf>.

21. See, e.g., James C. Robinson, *Renewed Emphasis on Consumer Cost Sharing in Health Benefit Design*, HEALTH AFF., Mar. 20, 2002, at w139, at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.139v1.pdf>; Marc A. Rodwin, *Backlash as Prelude to Managing Managed Care*, 24 HEALTH POL. POL'Y & L. 1115 (1999) (describing the "backlash" of consumer objections to limits imposed by managed care); Uwe E. Reinhardt, *Consumer Choice under "Private Health Care Regulation,"* in REGULATING MANAGED CARE: THEORY, PRACTICE, AND FUTURE OPTIONS 91-116 (Stuart H. Altman et al. eds., 1999) (arguing that employees resisted such limits in part because they perceived their care as free in the past). For a more personalized description of objections to managed care, see GEORGE ANDERS, *HEALTH AGAINST WEALTH: HMOs AND THE BREAKDOWN OF MEDICAL TRUST* (1996).

22. This picture can be complicated by managed care practices, such as preferred provider networks and referral requirements, that limit services covered by claims. See generally MICHAEL MORRISEY, *HEALTH INSURANCE* 131-145 (2007).

23. Insurance premiums also continue to rise (6.1% from 2006 to 2007). Gary Claxton et al., *Health Benefits in 2007*, 26 HEALTH AFF. 1407 (2007); KAISER FAMILY FOUNDATION & HEALTH RESEARCH AND EDUCATIONAL TRUST, *EMPLOYER HEALTH BENEFITS: 2007 ANNUAL SURVEY*, available at <http://www.kff.org/insurance/7672/upload/76723.pdf> (last visited March 1, 2008).

24. See generally Wendy K. Mariner, *Can Consumer-Choice Plans Satisfy Patients? Problems with Theory and Practice in Health Insurance Contracts*, 69 BROOK. L. REV. 485 (2004) (describing consumer-driven plans and arguing that they effectively ask patients to ration their own care) [hereinafter *Can Consumer-Choice Plans Satisfy Patients?*].

premiums or rewards for employees who participate in programs to prevent health risks, such as smoking cessation programs, exercise programs, and blood pressure and cholesterol screening programs. These programs can expand personal responsibility beyond financial liability to responsibility for one's own health status.²⁵

Social Solidarity

Given the complexity of medicine and disease, there may be good reason to create health insurance structures that aim for both universality and some degree of personal responsibility in coverage.²⁶ Nonetheless, those two goals pull insurance in opposite directions. This tension affects both private commercial insurance and public benefit programs, like Medicare, Medicaid, Veterans and military health benefit programs that are not formal insurance plans.

The concept of social solidarity embodies goals of mutual aid and support.²⁷ The idea is that we are all in this together, and no one should be abandoned. Such aspirations inspired early mutual aid societies to create insurance systems.²⁸ Where people are considered to be equally and randomly at risk for all types of medical problems, it makes sense for everyone to chip in and make sure that, when injury or illness occurs, help is available to anyone who needs it.²⁹ To fulfill their responsibilities to their populations, governments often adopt social insurance systems to finance health care.³⁰ The principle of mutual aid and support is evident in rules

25. See Part II *infra*.

26. See Robert J. Blendon et al., *Americans' Views of the Uninsured: An Era for Hybrid Proposals*, HEALTH AFF. w3-405, Aug. 27, 2003, at <http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.405v1/DC1> (reporting on public opinion surveys finding ambivalent views).

27. The concept of social solidarity may have originated with Émile Durkheim and his 1893 book, *THE DIVISION OF LABOR IN SOCIETY*, describing social cohesion.

28. DAVID MOSS, *SOCIALIZING SECURITY: PROGRESSIVE ERA ECONOMISTS AND THE ORIGINS OF AMERICAN SOCIAL POLICY* (1996); Stone, *Beyond Moral Hazard*, *supra* note 5 at 23-24; CAROL WEISBROD, *FAMILY, INSURANCE AND THE STATE* (2006).

29. See Deborah Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POL'Y & L. 287 (1993); Francois Ewald, *The Return of Descartes's Malicious Demon: An Outline of a Philosophy of Precaution*, EMBRACING RISK 273 (Tom Baker & Jonathan Simon eds. 2002).

30. See generally IN SEARCH OF RETIREMENT SECURITY: THE CHANGING MIX OF SOCIAL INSURANCE, EMPLOYEE BENEFITS, AND INDIVIDUAL RESPONSIBILITY (Teresa Ghilarducci et al. eds., 2005); STRENGTHENING COMMUNITY: SOCIAL INSURANCE IN A DIVERSE AMERICA (Kathleen Buto et al. eds., 2004); Western European countries have well-

for universality of coverage and community rating. Most systems bar medical underwriting that excludes people from coverage and prohibit or limit segmented markets and risk classification. The defining feature is that people are not excluded or asked to pay more because of their own health status, health risks or medical claims experience.

Even in the absence of universal social insurance, state and federal laws move commercial insurance toward social solidarity goals. For example, laws requiring guaranteed issue preclude insurers from excluding certain people from the pool.³¹ State laws requiring coverage of specific services (mandated benefits) embody social policies about what coverage must be available to all (except self-insured employee group plans exempted under ERISA). Most state laws forbid charging higher premiums to women, even if women are more likely than men to use medical care, at least during the child-bearing years.³² Many states also prohibit premium discrimination on the basis of genetic information.³³

The federal Health Insurance Portability and Accountability Act (HIPAA)³⁴ prohibits certain group health plans from discriminating in eligibility or premiums on the basis of health status factors, such as medical condition and claims experience.³⁵ More general anti-discrimination laws also foster social solidarity. For example, the federal Americans with Disabilities Act prohibits discrimination solely on the basis of disability in employee health insurance.³⁶ Title VII of the Civil Rights Act of 1964

known social insurance systems, with most using either a Bismarck model or a Beveridge model. Because they were created before private commercial health insurance developed a significant market, commercial insurers adapted their products to the goals of the government program. In contrast, American commercial health insurance established a strong commercial market largely independent of social insurance programs. *See* RICHMOND & FEIN, *supra* note 6.

31. *See e.g.*, 42 U.S.C. § 300gg-11 (guaranteed availability for employers in small group market and requirement to accept all eligible individuals in the small employer's group).

32. Most states also prohibit coverage exclusions or risk adjustment for women who are victims of domestic violence. *See, e.g.*, Ariz. Rev. Stat. § 20-448G; Fla. Stat. Ann. § 626.9541(g)(3); N.Y. Ins. Law § 2612. *See also* 29 U.S.C. § 1182 (a)(1)(G).

33. State law definitions of genetic information vary. *See* National Conference of State Legislatures, *Genetics & Health Insurance State Anti-Discrimination Laws*, June 2005, <http://www.ncsl.org/programs/health/genetics/ndishlth.htm> (last visited July 6, 2007).

34. 110 Stat. 1936 (Aug. 21, 1996), as amended (codified in scattered U.S.C. sections).

35. 29 U.S.C. § 1182. *See* note 81 *infra* and accompanying text.

36. Americans with Disabilities Act of 1990, 104 Stat. 328, 42 U.S.C. § 12101 et seq.

prohibits discrimination in employee benefits on the basis of race, color, religion, sex, or national origin.³⁷ Employee group health plans generally offer the same premium rate to all employees, regardless of age, health status, or claims experience.³⁸ Offering the same coverage for the same premium regardless of age is a significant example of solidarity, since health costs tend to increase with age and increase substantially among the elderly.³⁹

Personal Responsibility

Commercial insurance captures the concept of personal responsibility in efforts to achieve actuarial fairness. Here, the idea is that each person should pay for his own risks and no others. In contrast to social solidarity, the personal responsibility principle is that people are different and we should not be responsible for those who are different from us. Actuarially fair insurance policies classify and segregate insureds into groups according to the type and amount of risk they represent, with different coverage, exclusions, and premiums.⁴⁰ In health insurance, this means that the market for insurance is segmented into multiple categories with distinct products and pricing.

Commercial insurers may use medical underwriting and risk rating to classify people. Medical underwriting, used primarily in individual and small group policies in the United States, avoids insuring specific individuals or groups for non-fortuitous risks.⁴¹ They must have their own

37. Civil Rights Act of 1964, as amended, 42 U.S.C. § 2000e.

38. *But see* Part II *infra*, discussing discounted premiums for participating in wellness programs.

39. *See* Centers for Disease Control and Prevention & The Merck Company Foundation, State of Aging and Health in America 2007 Report, at 5 (2007) (reporting that the “cost of providing health care for one person aged 65 or older is three to five times greater than the cost for someone younger than 65”), available at <http://www.cdc.gov/aging/saha.htm>; Christine Borger et al., *Health Spending Projections Through 2015: Changes on the Horizon*, 25 HEALTH AFF. w61 (2006). *But see* Uwe E. Reinhardt, *Does the Aging of the Population Really Drive the Demand for Health Care?*, 22(6) HEALTH AFF. 27, 34-35 (2003), (arguing that research shows that a gradually increasing elderly population is not likely to cause disproportionate national cost increases, and that labor and administrative costs may play more important roles in raising costs).

40. ROBERT H. JERRY II, UNDERSTANDING INSURANCE LAW (2d ed. 1996); MALCOLM CLARKE, POLICIES AND PERCEPTIONS OF INSURANCE 256-57 (1997).

41. Medical underwriting may include investigating an applicant’s medical history, using information submitted on the application, medical claims, and prescription drug use. Insurers can deny the application entirely, refusing to cover the person. More commonly,

personal resources to pay for their most likely health problems. For coverage of other risks, actuarial fairness aligns premium rates with the risk profile of the person or group. Other payments, like the cost-sharing devices of deductibles and co-payments, serve both to discourage unnecessary medical care (and claims) and to engage the insured in effectively “insuring” her own losses to some degree.⁴² Coverage limits, which restrict the number of covered services, such as inpatient hospital days or specialist visits, can also discourage unnecessary care and claims.⁴³ Caps on paid claims, such as annual or lifetime limits on the dollar amount of health care expenditures covered, provide a ceiling on the insurer’s risk.

The complicated terms of commercial health insurance policies may be an inevitable consequence of the difficulty of determining what should count as a covered loss. While a broken limb or heart attack presents an unmistakable need for medical care, other health conditions are more ambiguous. What, if any, care is needed can often be debated, making the insurer’s risk more difficult to calculate.⁴⁴ Moreover, the cost of care varies significantly around the country.⁴⁵ Such concerns may not be unique to health insurance, but are undoubtedly more intense in assessing health insurance claims.

insurers exclude coverage for specific medical conditions (rider out those conditions) or increase premium rates to cover the conditions. They may also postpone coverage for pre-existing conditions. See Milliman, *INDIVIDUAL MEDICAL UNDERWRITING GUIDELINES, AND SMALL GROUP MEDICAL UNDERWRITING GUIDELINES* (updated periodically).

42. See, e.g., Herzlinger, *supra* note 6; John C. Goodman, National Center for Policy Analysis, *Characteristics of an Ideal Health Care System*, Policy Report No. 242 (April 2002), available at <http://www.ncpa.org/pub/st/st242/>.

43. See Tom Baker, *Containing the Promise of Insurance: Adverse Selection and Risk Selection*, 9 CONN. INS. L. J. 371 (2002/2003) (arguing that insurers can practice a form of adverse selection).

44. Examples include disputes over what services are “medically necessary” or “experimental.” Peter D. Jacobson et al., *Defining and Implementing Medical Necessity in Washington State and Oregon*, 34 INQUIRY 143 (1997); Mariner, *Can Consumer-Choice Plans Satisfy Patients?*, *supra* note 24 at 537-38 (collecting studies).

45. John E. Wennberg & Alan Gittelsohn, *Small Area Variations in Health Care Delivery*, 182 SCIENCE 1102 (1973). For a recent collection of articles on variation in medical practice, see *Variations Revisited*, HEALTH AFF., Oct. 7, 2004, <http://content.healthaffairs.org/cgi/content/full/hlthaff.var.1/DC1>.

Insurance Policies and Service Contracts

Fundamental to the concept of insurance is the premise that covered risks should be fortuitous—that is, unplanned and unanticipated.⁴⁶ State laws and market demand, however, have introduced exceptions to the fortuity principle in many health insurance policies. The result may be confusion about what counts as an insurable risk.

The best known exception is coverage of preventive services, such as immunizations, disease screening (e.g., mammograms), dental cleaning, prenatal care, well baby visits, and annual physical examinations. There are undisputed social policy reasons for these exceptions; such services can prevent disease and keep people healthy.⁴⁷ Statutory requirements for insurance coverage are generally based on concerns that many people, especially in low-income groups, would not obtain such services if they had to pay for them out of pocket. Insurance coverage encourages prevention by paying for it.⁴⁸ Moreover, preventive services typically cost less than treatment for the disease they prevent.⁴⁹ These are sound rationales for encouraging prevention, but they do not fit insurance well.

46. Classic elements of an insurable risk are a measurable probability of loss (predictable within a defined population) and individual uncertainty of loss (the fortuity principle). ERIC MILLS HOLMES & MARK S. RHODES, 1 APPLEMAN ON INSURANCE §1.4 (2d ed. 1996) (“The fortuity principle is central to the notion of what constitutes insurance. The insurer will not and should not be asked to provide coverage for a loss that is reasonably certain or expected to occur within the policy period.”); GEORGE J. COUCH, 2 COUCH ON INSURANCE 2D § 2:7 (rev. ed. 1984) (“Risk . . . is the very essence of insurance. . . . It should relate to a possibility of real loss which neither the insured nor the insurer has the power to avert or hasten.”); LEE R. RUSS & THOMAS F. SEGALLA, 7 COUCH ON INSURANCE §101.2 (3d ed. 1997 & Supp. 1999) [hereafter “COUCH”] (“In general, the loss must occur as a result of a fortuitous event, not one planned, intended, or anticipated.”). See also Stephen A. Cozen & Richard C. Bennett, *Fortuity: The Unnamed Exclusion*, 20 FORUM 222 (1985) (noting that the fortuity principle is so essential to insurance that it does not explicitly appear in the text of insurance policies).

47. See generally HANDBOOK OF HEALTH PROMOTION & DISEASE PREVENTION (James M. Raczynski & Ralph J. DiClemente eds., 1999); U.S. DEPT. OF HEALTH AND HUMAN SERVICES, I HEALTHY PEOPLE 2010: UNDERSTANDING AND IMPROVING HEALTH AND OBJECTIVES FOR IMPROVING HEALTH (2000), available at <http://www.health.gov/healthypeople/document/>.

48. The alternative to requiring everyone to obtain or pay for their own preventive services would undoubtedly provoke a public outcry, especially in light of the individual’s well-settled right to refuse medical treatment of any kind. See GEORGE J. ANNAS, THE RIGHTS OF PATIENTS 277-8 (3d ed. 2004).

49. But see Pieter H. M. van Baal et al., *Lifetime Medical Costs of Obesity: Prevention No Cure for Increasing Health Expenditure*, 5(2) PLOS MEDICINE e29 (2008)

The use of insurance to achieve desirable public policy goals challenges the nature of commercial insurance. Preventive care is not a typical insurable risk, because it is predictable and under the control of the insured.⁵⁰ The specific services are explicitly paid for whenever the insured chooses to obtain them. Insurers can predict the cost of such coverage, but assume no risk, removing the agreement from of the realm of insurance. Instead, the insurance payments to health providers function like assets of the insured to pay for a defined set of services. The result looks more like a service contract than an insurance policy.

Health reimbursement accounts (HRAs) expand the service contract concept beyond preventive care.⁵¹ A particular type of HRA, the health savings account (HSA), has become more attractive to individuals and employee group health plans since receiving favorable tax treatment.⁵² Although not yet widespread,⁵³ HRAs and HSAs are the current paradigm

(lifetime health care expenditures were higher for “healthy-living” persons than for overweight and obese persons and smokers, because the former lived longer).

50. See, e.g., *SCA Servs. Inc. v. Transportation Ins. Co.*, 419 Mass. 528, 532, 646 N.E.2d 394, 397 (1995) (explaining that a risk that the insured knows is likely to happen “ceases to be contingent and becomes a probable or known loss”). See generally 7 COUCH §102.9 (p. 102).

51. A health reimbursement account is a dedicated fund (from the employer and/or employee contributions) that can be used by a plan participant to pay certain medical expenses. For a description of such plans, see Paul Fronstin & Sara R. Collins, *The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Survey 2006: Early Experience with High-Deductible and Consumer-Driven Plans*, EBRI ISSUE BRIEF No. 300 (Dec. 2006), available at www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=3769.

52. The Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. 108-173, §101, 117 Stat. 2066 (2003), allows taxpayers to exclude from taxable income funds placed in an HSA, provided that it is coupled with a high deductible health plan (HDHP). See also Revenue Ruling 2002-41, 2002-28 I.R.B. 75 (employer’s contribution to HSA is not taxable if funds are used to pay certain medical expenses). See Timothy S. Jost & Mark A. Hall, *The Role of State Regulation in Consumer-Driven Health Care*, 31 AM. J. L. & MED 395 (2005).

53. See America’s Health Insurance Plans, HSAs and Account-Based Health Plans – An Overview of Preliminary Research, June 2006 (reporting 3.2 million people enrolled in HSA-qualified plans in January 2006), available at www.ahipresearch.org/pdfs/HSAsOverviewJun2006.pdf; and Melinda Beeuwkes Buntin et al., *Consumer-Directed Health Care: Early Evidence About Effects on Cost and Quality*, HEALTH AFF. Web Exclusive w516, w518 (Oct. 24, 2006) (reporting 2.9 million enrolled in HRAs in January 2006). Together, the 6.1 million may account for “about 3 percent of the commercial insurance market”. *Id.* at w518. But see Fronstin & Collins, *supra* note 51 (finding 1.3 million nonelderly adults enrolled in consumer-directed health plans); Gary Claxton et al., *Health Benefits in 2006: Premium Increases Moderate, Enrollment in Consumer-Directed Health Plans Remains Modest*, 25 HEALTH AFF. Web Exclusive w476

for so-called “consumer-directed” care, described as giving consumers more choice than they had with regular health insurance, primarily managed care plans. Both supporters and critics agree that such accounts are designed to make consumers more cost-conscious by forcing them to pay for a portion of their care.⁵⁴ Although there is as yet little data about how most individuals spend their account funds, it is likely that most are spent on preventive care and less expensive, less costly, discretionary medical services, such as treatment for colds and influenza.⁵⁵ Shifting this kind of care out of the defined benefit package trims health plans of their coverage of some non-fortuitous risks. While there are limits on the type of care for which the funds can be used, HRA accounts move responsibility for choosing and paying for care back onto the individual.

Health reimbursement accounts embody the view of some health economists and policy analysts that health insurance is a personal financial asset that can be used to buy medical care at the consumer’s discretion, a view at odds with that of insurance purists. In this economic view, insurance distorts the market for health care by enabling, even encouraging, individuals to buy more care than they need, or at least more care than is economically efficient for the country.⁵⁶ Here, the focus of analysis is the purchase of health care; insurance is merely a source of funds for payment.

(Sept. 26, 2006), available at <http://content.healthaffairs.org/cgi/reprint/25/6/w476?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=Claxton&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT>.

54. Mariner, *Can Consumer-Choice Plans Satisfy Patients?*, *supra* note 24. See also Alain C. Enthoven, *Employment-Based Health Insurance Is Failing: Now What?*, HEALTH AFF. May 28, 2003, at w3-237, w3-239 (“The popular ‘consumer-driven’ or ‘defined contribution’ models are no more than a cover for high deductibles, intended to make consumers cost-conscious shoppers.”), at <http://content.healthaffairs.org/cgi/reprint/hltaff.w3.237v1.pdf>; and Vanessa Fuhrmans, *Health Savings Plans Start to Falter*, WALL STREET J. D1, June 12, 2007 (reporting 2.7 million enrolled in 2006, and lower satisfaction with such plans among participants).

55. See Buntin, *Consumer-Directed Health Care*, *supra* note 53 at w519 (reporting on studies showing that people who enroll in high-deductible consumer-directed plans are healthier and have higher incomes than those who remain in more traditional plans); U.S. GOVERNMENT ACCOUNTABILITY OFFICE, CONSUMER-DIRECTED HEALTH PLANS: EARLY ENROLLEE EXPERIENCES WITH HEALTH SAVINGS ACCOUNTS AND ELIGIBLE HEALTH PLANS (2006) (younger and higher income federal employees joined CDHPs in the Federal Employees Health Benefits Program).

56. See, e.g., Herzlinger, *supra* note 6; CLARK C. HAVIGHURST, HEALTH CARE CHOICES, *supra* note 11; Joseph P. Newhouse, *Medical Care Costs: How Much Welfare Loss?*, 6(3) J. OF ECONOMIC PERSPECTIVES 321 (1992).

In contrast, the traditional insurance industry view is that its product is a promise to pay only for specified losses. In this view, an insurance policy is not a cash equivalent to pay for whatever the insured chooses to buy. Therefore, HRAs, like coverage of preventive services, distort insurance. While health economists argue that consumers should be deliberate, rational purchasers of care, insurers expect to pay only for fortuitous losses. Pairing HRAs with defined benefit insurance policies couples very different conceptions of the function of insurance.

Some economists concerned about national health expenditures object to generous insurance policies on the ground that they buy too much care.⁵⁷ But, the reason we have insurance is to pay for losses that we could not otherwise afford. If health care is a consumer good, freely bought and sold in the marketplace, then it should not matter what resources consumers use to buy it. Wages, daddy's trust fund, and health insurance are all cash equivalents. Moreover, if health care is a consumer good, who cares what people buy? Why not let the market determine what services people value? Of course, the main reason for objecting to unrestrained spending is that it raises the price of care so that not everyone can afford it.⁵⁸ Yet unaffordability matters only if health care is something more than an ordinary consumer good, something that should be available to everyone regardless of ability to pay.⁵⁹ Thus, the economic argument against buying too much care supports the idea of social solidarity in ensuring access to

57. See generally THOMAS RICE, *THE ECONOMICS OF HEALTH RECONSIDERED* (2d ed. 2003). Some commentators argue that consumers should buy insurance that limits their freedom to choose expensive care. See, e.g., MARK A. HALL, *MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING MECHANISMS* (1997).

58. Some commentators argue that insurance creates moral hazard, encouraging too much care. Peter Zweifel & William G. Manning, *Moral Hazard and Consumer Incentives*, 1A *HANDBOOK OF HEALTH ECONOMICS* (Anthony J. Culyer & Joseph P. Newhouse eds., 2000); Mark V. Pauly, *The Economics of Moral Hazard: Comment*, 58 *AM. ECON. REV.* 531 (1968). But moral hazard addresses the effects of insurance, not ordinary consumer contracts. Tom Baker, *On the Genealogy of Moral Hazard*, 75 *TEX. L. REV.* 237 (1996). Moral hazard may corrupt insurance claims for property losses, but is probably less significant in health insurance than in other types of insurance.

59. For arguments that health care is special in this sense, see *supra* note 12. Although an insurance policy may be a consumer product, the insurer's purchase of services to pay an insurance claim differs from the consumer/patient's direct purchase of services. The latter may come into play for the deductible amount in a high-deductible plan or HRA. See Sara R. Collins, *Consumer-Drive Health Care—Why It Won't Solve What Ails the United States Health System*, 28 *J. LEGAL MED.* 53 (2007) (summarizing studies finding that higher cost sharing discourages people from getting care, with people with incomes lower than \$50,000 twice as likely to avoid or delay care as those in other plans).

care for everyone.⁶⁰ Paradoxically, however, the solution offered to rising health care costs—making people responsible for more of their care—weakens social solidarity.

Summary

The exceptions to traditional indemnity insurance for insurable risks are usually justified on one of two grounds: cost (to society at large, government or private insurers, or employers who contribute to premiums); or social policy (to improve health, encourage “good” behavior or discourage “bad” behavior). In many cases, both reasons are intertwined, so that is difficult to disentangle one from another, as may be seen in the example of wellness programs discussed below. Adding exceptions for these reasons may make some sense in a universal social insurance system, where everyone is in the pool, to remove financial barriers to important services. Adding them to private insurance sold in the commercial market outside the context of a universal social insurance system, however, may simply widen the sphere of personal responsibility.

Neither social solidarity nor personal responsibility principles, by themselves, can explain or justify the package of health insurance reforms put forward today. Coverage of some conditions and services reflect social solidarity, while other provisions encourage personal responsibility and treat health care as a consumer good. Implicit in this division of reform provisions is the idea that some conditions are socially acceptable, such that all society ought to share (at least financial) responsibility for their prevention or consequences, while other conditions are socially unacceptable, such that individuals should shoulder the burden themselves.⁶¹ Yet there has been little debate about what principles ought to govern classifying particular health conditions as either an individual responsibility or a social responsibility.

60. See Clark C. Havighurst & Barak D. Richman, *Distributive Injustice(s) in American Health Care*, 69 LAW & CONTEMP. PROB. 7, 38-39 (2006) (arguing that the goal of reducing consumer demand for health services might have been better met by capping the “tax subsidy” or issuing government vouchers).

61. It brings to mind the concept of the “deserving poor,” used to distinguish those who deserved charity or government benefits from those who did not. See JOEL F. HANDLER & ELLEN JANE HOLLINGSWORTH, *THE DESERVING POOR* (1971); CHARLES E. ROSENBERG, *THE CARE OF STRANGERS* 23 (1987).

II. THE PECULIAR CASE OF WELLNESS PROGRAMS

The most recent examples of allocating health conditions to the personal responsibility side of the equation are wellness programs. When offered as part of a health insurance plan, such programs fall on the services side of the insurance + services contract, with the individual earning rewards for performing specific tasks or incurring a loss for failing to do so. For example, those who get screened for hypertension or high cholesterol might receive a discount on their health plan premium. Those who attend regular exercise programs might avoid paying the plan's deductible. Those who take medication as prescribed might have their drug co-payment waived. Those who fill out a personal health history and agree to be called by a disease management company may get cash prizes. The specific conditions for which financial differences are allowed offer some insight into what we hold people personally responsible for.

First adopted by a small (now growing) number of employee group health plans, wellness programs are intended to keep employees healthy and productive and to reduce health insurance costs.⁶² It is not clear which goal takes precedence. Private employers who support health goals may also need to see a financial return in order to sustain wellness programs.⁶³ Some employees welcome the programs, while others object that they are intrusive and unrelated to job performance or consider them a mechanism to get rid of the employees most likely to incur expensive medical claims.⁶⁴ Even the *Wall Street Journal* worried that employers who monitor their employees' health may be overreaching.⁶⁵

62. See Susan Okie, *The Employer as Health Coach*, 357 NEW ENGL. J. MED. 1465 (2007); Ellen Simon, *Survey: Large Firms to Offer Health Care*, WASH. POST, April 19, 2007 (reporting survey finding that 63% of 448 large companies plan to cut costs by improving employee health); available at <http://www.washingtonpost.com/wp-dyn/content/article/2007/04/19/AR2007041800103.html>. Anecdotal reports suggest that some companies save money on hospital and productivity costs. M.P. McQueen, *Wellness Plans Reach Out to the Healthy*, WALL STREET J. D1, March 28, 2007.

63. Patty Enrado, *ROI on Health Management Programs Difficult to Measure*, HEALTHCARE IT NEWS, June 22, 2007 (reporting that 70% of employers surveyed believe that programs must produce a financial return on investment greater than break-even to be acceptable), available at <http://www.healthcareitnews.com/story.cms?id=7321>.

64. Tresa Baldas, *Wellness by Decree*, NATIONAL LAW JOURNAL at 1, 18, Nov. 26, 2007; *Workers Penalized on Issues of Health*, BOSTON GLOBE at E3, Sept. 10, 2007.

65. M.P. McQueen, *Look Who's Watching Your Health Expenses*, WALL STREET JOURNAL, Sept. 25, 2007.

Public health agencies generally support programs for smoking cessation, screening for diseases, losing weight, and regular physical exercise for general health goals.⁶⁶ However, such groups are not responsible for offering or regulating insurance. State Medicaid and commercial insurance reform laws that allow financial incentives for wellness programs might have been adopted for either health or financial goals.⁶⁷

Whether wellness programs can justify themselves with cost savings remains to be seen. Estimates of financial savings are often based on general population data.⁶⁸ Research on the costs and savings from specific preventive measures is limited.⁶⁹ Recent reports find that most interventions produce little or no reduction in total health care spending, while many increase costs.⁷⁰ Some well constructed health promotion programs that positively engage individuals and some specific preventive

66. See, e.g., Press Release, American Public Health Association (APHA), APHA Encourages All to Participate in Take a Loved One for a Checkup Day (Sept. 18, 2006), available at <http://www.apha.org/about/news/pressreleases/2006/06checkup.htm>. See generally INSTITUTE OF MEDICINE, COMMITTEE ON PREVENTION OF OBESITY IN CHILDREN AND YOUTH, PREVENTING CHILDHOOD OBESITY: HEALTH IN THE BALANCE (2005); Michael McGinnis, *The Case for More Active Policy Attention to Health Promotion*, 21 HEALTH AFF. 78 (Mar.-Apr. 2002); Wendy K. Mariner, *Law and Public Health: Beyond Emergency Preparedness*, 38 J. HEALTH L. 247, 259 (2005) (noting increased support for health promotion among public health professionals).

67. See, e.g., 2006 Mass. Acts 58, §54 (authorizing the Massachusetts Medicaid program to create wellness programs and to reduce MassHealth premiums or co-payments for “enrollees who comply with the goals of the wellness program”); §§ 76-79 (requiring community rating for commercial insurance without regard to health status but permitting premiums to vary based on wellness program usage, tobacco usage age, group size, industry, participation rate, geographic area, and benefit levels). However, the Medicaid program does not charge premiums to enrollees, so the legislature may consider alternative mechanisms for encouraging compliance.

68. See Paul Fronstin, *Can “Consumerism” Slow the Rate of Health Benefit Cost Increases?*, EBRI ISSUE BRIEF, No. 247, July 2002 (reporting that 10% of the population accounted for 58% of health expenditures).

69. See generally PREVENTION EFFECTIVENESS: A GUIDE TO DECISION ANALYSIS AND ECONOMIC EVALUATION, 2d ed. (Anne C. Haddix et al. eds., 2003).

70. Joshua T. Cohen et al., *Does Preventive Care Save Money? Health Economics and the Presidential Candidates*, 358 NEW ENGL. J. MED. 661, 662-3 (2008); Louise B. Russell, *Prevention’s Potential for Slowing the Growth of Medical Spending* (National Coalition on Health Care, Oct. 2007), available at www.nchc.org/nchc_report.pdf; Matthew G. Marin & Jessica Nutik Zitter, *Expenditures Associated with Preventive Health Care*, 39 PREVENTIVE MEDICINE 856 (2004).

measures, like immunizations, can save medical expenses.⁷¹ However, the promise of broader wellness programs may not be realized without a long-term investment. Set up costs are concentrated in the early years, with savings beginning years later when (and if) participants avoid expensive services. Full benefits to the insurer or employer depend on long-term enrollment by individual participants. In private health plans, about 17 percent of participants change plans every year.⁷² This weakens the financial incentive to offer wellness programs, unless competing plans have similar programs.⁷³

While wellness programs may produce better health, one probably ought not to expect financial miracles. Unless such programs stave off illnesses that are more expensive than other diseases not targeted, they may simply shift the causes, not the costs, of illness.⁷⁴ Preventive measures

71. S.G. Aldana, *Financial Impact of Health Promotion Programs: A Comprehensive Review of the Literature*, 15 AM. J. HEALTH PROMOTION 296 (2001); Sheila Leatherman et al., *The Business Case for Quality: Case Studies and an Analysis*, 22(2) HEALTH AFF. 17, 21 (2003) (reporting total expenditures of \$330 per patient and \$405 in savings over a 9-year period in a diabetes management program); Reducing Health Care Costs Through Prevention – Working Document, Prevention Institute and The California Endowment with The Urban Institute (2007), available at www.preventioninstitute.org/documents/HE_HealthCareReformPolicyDraft_091507.pdf.

72. Peter J. Cunningham & Linda Kohn, *Health Plan Switching: Choice or Circumstance?*, 19(3) HEALTH AFF. 158, 159 (2000) (also finding that more than 2/3 changed plans because they changed employment or their employer changed the plans offered; 16% switched to a less expensive plan and about 8% moved to a plan they liked better).

73. Since patients change physicians less often than they change health plans, wellness programs might improve their results by rewarding physicians (instead of patients) who educate their patients about prevention and manage medical conditions well. See, e.g., Massachusetts Blues Expanding Incentives for Preventive Care, Disease Management, 11(1) BNA'S HEALTH CARE POLICY 22 (Jan. 6, 2003) (describing providing information to primary care physician groups about their patients, such as mammograms conducted, and paying higher fees to groups that provide preventive services).

74. Targeting particular conditions may have unintended consequences. See, e.g., Steven E. Nissen & Kathy Wolski, *Effect of Rosiglitazone on the Risk of Myocardial Infarction and Death from Cardiovascular Causes*, 356 NEW ENGL. J. MED. 2457 (2007) (meta-analysis of studies, concluding that a drug widely used to treat type 2 diabetes may slightly increase the risk of risk of myocardial infarction and death from cardiovascular disease); 'Diabulima': Some Diabetic Girls Skip Insulin in Dangerous Effort to Lose Weight, APA OnLine, June 17, 2007, available at <http://psycport.apa.org/showArticle.cfm?xmlFile=ap%5F2007%5F06%5F17%5Fap%2Eworldstream%2Eenglish%5FD8PQO2HG0%5Fnews%5FFap%5Fforg%2Eanpa%2Eew%2Exml&provider=Associated%20Press>.

cannot guarantee good health or immortality.⁷⁵ Nor do they affect the cost of care that is provided, which continues to rise.⁷⁶ Indeed, there is some evidence that the lifetime costs are greater for healthy people than for smokers or obese people.⁷⁷ The best that may be hoped for is disease compression—postponing debilitating illness to very short period before death at a ripe old age.⁷⁸

Wellness Programs within Health Insurance Plans

The key difference between indemnity insurance and wellness programs is how risk information is used. Insurers typically use risk data to set rates. A risk-rated insurance policy would base the premium on the individual's risk factors or, in the case of a group policy, on the group's overall risk. A wellness program uses risk data to selectively modify rates for individuals who are already in the risk-rated pool. In theory, it is the insured, instead of the insurer, who changes the rate—by complying with the program's requirements. Generally, however, everyone in the group who does not have a particular risk factor, like smoking or diabetes, receives a discount or reward. The effect is to charge higher rates to individuals based on their personal health risks.

A well-publicized example was the plan adopted by Clarian Health, an Indiana hospital system, to charge employees bi-weekly fees if they failed

75. See SARA ALLIN et al., MAKING DECISIONS ON PUBLIC HEALTH: A REVIEW OF EIGHT COUNTRIES (2004) (finding little empirical evidence on the effectiveness and costs of prevention programs); CONGRESSIONAL BUDGET OFFICE, AN ANALYSIS OF THE LITERATURE ON DISEASE MANAGEMENT PROGRAMS (Oct. 2004); David Ogilvie, *Interventions to Promote Walking: Systematic Review*, 334 BRIT. MED. J. 1204 (2007) (finding that the sustainability and clinical benefits of walking programs are uncertain); LOUISE B. RUSSELL, IS PREVENTION BETTER THAN CURE? (1986) (questioning broad prevention claims).

76. David Leonhardt, *Free Lunch on Health? Think Again*, N.Y. TIMES 1, 9 (Aug. 8, 2007) (quoting former New York state health commissioner as saying preventive care “reduces costs, yes, for the individual who didn’t get sick. But that savings is overwhelmed by the cost of continuously treating everybody else.”). See also HENRY J. AARON & WILLIAM B. SCHWARTZ, THE PAINFUL PRESCRIPTION: RATIONING HOSPITAL CARE (1984) (describing the role of technology in increasing costs and the need for rationing care).

77. Van Baal, *supra* note 49 (estimating lifetime expenditures for health care for three groups of people, with healthy having the highest costs, obese medium costs, and smokers lowest costs).

78. See DANIEL CALLAHAN, THE TROUBLED DREAM OF LIFE 123 (1993) (“To be mortal is to live a life that will be marked by illness, injury, aging, decline, and death. . . . We can reasonably hope that the decline of our bodies that will come with age can be lessened, delayed, and compensated for. . . . Though we will and must die, we can hope that we will not die sooner than necessary. . . .”).

to meet target health standards, beginning in 2009:⁷⁹ US\$10 if BMI \geq 30; \$5 for blood pressure $>140/90$; \$5 for glucose levels > 120 ; \$5 for low density lipoprotein cholesterol > 130 ; \$5 for smoking; and \$5 for not completing a health assessment. After public opposition to its plan, Clarion made the program voluntary and withdrew the penalties on those who fail to meet the targets. Instead, it will offer the same amounts as bonuses to those who voluntarily meet the targets.⁸⁰ The effect, however, may be the same.

Laws forbidding medical underwriting and basing premium rates on individual health risks would seem to prohibit this result. Nevertheless, as discussed below, wellness programs have joined preventive services as an exception to the fortuity principle in many health insurance plans. However, unlike coverage of preventive care, wellness program coverage costs participants different amounts depending upon their behavior. The specific conditions for which financial differences are set offer some insight into what we hold people personally responsible for.

Discrimination on the Basis of Health Factors and the HIPAA Wellness Exception

The tension between rewarding wellness and banning discrimination based on health risks may be reflected in the fact that it took the federal government more than a decade to issue final HIPAA regulations governing group health plan wellness programs.⁸¹ Like several health insurance reform proposals, the Act prohibits discrimination on the basis of health factors while simultaneously allowing group health plans to offer financial rewards for “adherence to programs of health promotion and

79. Jena McGregor, *Being Unhealthy Could Cost You—Money*, BUSINESS WEEK, Aug. 5, 2007, available at www.businessweek.com/bwdaily/dnflash/content/aug2007/db2007081_804238.htm?chan=search.

80. *Clarian Won't Dock Workers Who Fail to Meet Health Standards*, INDIANAPOLIS STAR, Nov. 1, 2007, available at www.tmcnet.com/usubmit/2007/11/01/3064048.htm.

81. Dept. of Treasury, Dept. of Labor, Dept. of Health and Human Services, Nondiscrimination and Wellness Programs in Health Coverage in the Group Market; Final Rules, 71 FED. REG. 75013 (Dec. 13, 2006). The final rules add parallel provisions to regulations implementing the Internal Revenue Code, the Employee Retirement Income Security Act, 29 U.S.C. § 1001 et seq., and HIPAA requirements for certain small group and individual plans added to the Public Health Service Act. *Id.*

disease prevention.”⁸² Health factor is broadly defined and includes health status (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability.⁸³ Forms of discrimination include rules imposing waiting periods, coverage exclusions and limits, benefit restrictions, premium contributions, and cost-sharing mechanisms (such as coinsurance, co-payments, and deductibles), as well as exclusions from participation in a plan.⁸⁴ The final regulations, issued in December 2006, attempt to reconcile the exception for wellness programs with the general prohibition against discrimination on the basis of any health factor.⁸⁵ The difficulty of doing so can be seen in the examples of acceptable programs described in the regulations and discussed below.

A wellness program (defined as “any program designed to promote health or prevent disease”) will qualify for the exception if “none of the conditions for obtaining a reward under a wellness program is based on an individual satisfying a standard that is related to a health factor” as long as “participation in the program is made available to all similarly situated individuals.”⁸⁶ Among the rule’s examples of acceptable wellness programs are those that reimburse all or part of fitness center membership fees or smoking cessation programs; provide rewards for participating in diagnostic testing programs (and do not base rewards on test outcomes) or monthly health education seminars; and waive co-payments or deductibles for prenatal care or well-baby visits.⁸⁷

Nonetheless, programs that do base rewards on an individual satisfying a health-related standard can still qualify for the exception if they meet four criteria: (1) the value of the reward is not more than 20 percent of the

82. 29 U.S.C. § 1182 (a) (prohibiting group health plans from conditioning eligibility on a health factor); 29 U.S.C. § 1182 (b)(1) (forbidding group health plans from requiring “any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor”); and 29 U.S.C. § 1182 (b)(2)(B) (providing that paragraph (1) shall not be construed “to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.”).

83. 29 U.S.C. § 1182 (a).

84. 29 C.F.R. § 2590.702.

85. *Id.*

86. 29 C.F.R. § 2590.702 (f)

87. 29 C.F.R. § 2590.702 (f)(1).

premium for the participant (including both employer and employee contributions); (2) the program must be “reasonably designed to promote health or prevent disease”; (3) eligible individuals must be able to qualify for the reward at least once a year; and (4) the program must be available to all similarly situated individuals.⁸⁸ Even this exception to the exception has its own exception. Individuals cannot be required to meet the health standard if to do so is “unreasonably difficult due to a medical condition” or “medically inadvisable.”⁸⁹ Such individuals must be given “a reasonable alternative standard.”⁹⁰

The rules’ examples indicate that it should be easy to qualify for these exceptions, even if the program requires participants to achieve specific health targets. Two examples approve wellness programs that require patients to obey a physician’s recommendations in order to qualify for discounts. In one example, a wellness program offers a 20 percent premium discount to employees who achieve a cholesterol count under 200. The plan offers to “work with” employees who are unable to achieve that goal. One employee, “D”, begins a diet and exercise program, but his physician determines that D cannot lower his cholesterol below 200 without taking prescription medication. The plan “accommodates D by making the discount available to D, but only if D follows the advice of D’s doctor regarding medication and blood tests.”⁹¹ The rules conclude that this program qualifies for the exception and is permissible.

A second example describes a wellness program that waives the \$250 annual deductible for participants who have a body mass index (BMI) between 19 and 26. Those who are unable to lose enough weight for medical reasons can earn the reward by walking 20 minutes a day 3 days a week. A medical condition prevents individual E from meeting either standard. The rules approve a result in which the “plan agrees to make the discount available to E if E follows the physician’s [unspecified] recommendations.”⁹²

It is hard to argue that these examples do not discriminate on the basis of a health factor. The conclusion that they are not discriminatory appears to rely on the assumption that, if all else fails, health plans can force participants to follow a physician’s recommendations. Although it is doubtful that employers could require employees to obey their physicians

88. 29 C.F.R. § 2590.702 (f)(2).

89. 29 C.F.R. § 2590.702 (f)(2)(A).

90. *Id.*

91. 29 C.F.R. § 2590.702 (f) Example 3.

92. 29 C.F.R. § 2590.702 (f) Example 4.

as a general condition of employment, some employers are refusing to hire smokers on the ground that they have higher health insurance claims than non-smokers.⁹³ The same reasoning could be applied to similarly costly conditions, such as obesity.⁹⁴ Conditions like hypertension are not likely to be considered disabilities for purposes of the Americans with Disabilities Act to preclude employers from not hiring individuals with those conditions.⁹⁵ Nonetheless, they are certainly considered health conditions for purposes of wellness programs.

One might argue that these examples simply involve eligibility for rewards (in the form of discounts) that would not otherwise be available. The distinction between rewards and penalties, however, is often in the eye of the beholder.⁹⁶ Moreover, some programs do impose penalties. The HIPAA rules approve the example of a wellness program that imposes an explicit financial penalty—a surcharge of 20% of the premium—on participants who do not certify that they have not used tobacco products in the past year.⁹⁷ The surcharge can be avoided if a participant is addicted to nicotine and participates in a smoking cessation program.⁹⁸

93. See, e.g., *Rodrigues v. The Scotts Company*, ___ F. Supp. 2d ___, CA 07-101104-GAO (D. Mass. Jan. 30, 2008) (denying company's motion to dismiss claims of invasion of privacy under state law and discrimination under ERISA § 510 by employee who was fired for smoking off the job); WHO Extinguishes Smokers' Job Prospects, *GUARDIAN UNLIMITED*, Dec. 2, 2005, available at http://blogs.guardian.co.uk/news/archives/2005/12/02/who_extinguishes_smokers_job_prospects.html; Jeremy W. Peters, *Company's Smoking Ban Means Off-Hours, Too*, N.Y. TIMES, Feb. 8, 2005, at C5. See also Daniel M. Warner, "We Do Not Hire Smokers," 7 EMP. RESP. & RTS. J. 129 (1994) (explaining discrimination against smokers as both legal and good policy). But see Leonard Glantz, *Smoke Got in Their Eyes*, WASH. POST at B07, Dec. 18, 2005 (criticizing WHO's decision not to hire smokers as endorsing the principle that "employers can impose job requirements based on what employees do off the job").

94. See Truls Ostbye, *Obesity and Workers' Compensation: Results from the Duke Health and Safety Surveillance System*, 167 ARCHIVES OF INTERNAL MEDICINE 766 (2007) (finding that obese workers had higher medical costs and worker compensation claims than non-obese employees).

95. See *Chevron U.S.A. Inc. v. Echazabal*, 536 U.S. 73 (2002).

96. Daniel I. Wikler, *Persuasion and Coercion for Health: Ethical Issues in Government Efforts to Change Life-Styles*, 56 MILBANK MEMORIAL FUND Q. 303 (1978).

97. 29 C.F.R. § 2590.702 (f) Example 5.

98. One might ask what counts as addiction and how long a participant will be allowed to avoid the surcharge in practice. The majority of smokers enrolled in smoking cessation programs fail to quit. Leatherman et al., *The Business Case for Quality*, *supra* note 71 at 21 (describing quitting rates of 25 to 30% among smokers in a well regarded smoking cessation program). See also H.A. Tindle et al., *Cessation among Smokers of "Light" Cigarettes: Results from the 2000 National Health Interview Survey*, 96 AM. J. PUB. HEALTH 1498 (2006) (finding that 53% of smokers quit, while 37% of light cigarette smokers quit).

Much of the justification for these programs depends on the idea that rewards and penalties are equally available to “all similarly situated individuals.” Yet rewards are available only to people who do not have the health condition at issue and to people who conform to the program’s requirements.⁹⁹ Thus, they function as incentives to conform to specific standards as a condition of employment or as a condition of obtaining insurance coverage. In principle, it is only the price of coverage, not coverage itself, that is conditional on compliance. Yet, if the costs of coverage depend on satisfying specific health standards, then costs are based on health factors. They are the same risk factors that insurers would ordinarily take into account in determining premium rates, absent the statutory prohibition against discrimination. In effect, therefore, wellness programs reintroduce the very risk rating that legislation aimed at social solidarity initially forbade.

Implications for Social Solidarity

In addition to introducing selective personal responsibility into insurance pools, the focus on wellness programs’ ability to save costs has two disadvantages. First, as noted above, such programs may not save significant sums, especially if healthy people cost more in the long run. More importantly, it discounts improved health and wellbeing as valuable for their own sake. This may discourage independent initiatives to promote health unless they prove financially rewarding.

Wellness programs depart from social solidarity in at least two other ways. First, to the extent that they succeed in improving health and reducing costs, they may benefit the federal government more than the private sector, further dividing the country along lines of coverage. Although employers and insurers may take short-term health care costs into account, government may pay closer attention to total lifetime costs of all benefits.¹⁰⁰

Current wellness programs target risk factors for chronic diseases, which account for about three-quarters of the costs of medical care in the

99. After non-smokers took up smoking to get paid for stopping, one employer was quoted as saying, “It was not our intention to encourage people to start smoking. It was aimed at people who already had a bad habit.” M.P. McQueen, *Wellness Plans Reach Out to the Healthy*, WALL ST. J. at D1, March 28, 2007.

100. Timothy Westmoreland, *Can We Get There from Here? Universal Health Insurance and the Congressional Budget Process*, 96 GEO. L. J. 523, 529 (2008).

U.S.¹⁰¹ In 2004, 62 percent of adult respondents, age 50 to 64, reported having at least one of six chronic conditions (hypertension, heart disease, cancer, diabetes, arthritis, or high cholesterol).¹⁰² National data for the same year show that the percentage of adults with three or more chronic conditions was 7 percent for those age 45 to 54, and 36 percent for those over 75 years of age.¹⁰³ Because the incidence of chronic conditions increases with age, older adults face higher medical costs. Moreover, the percentage of adults between 45 and 75 years of age with chronic conditions rose as their income declined.¹⁰⁴

Type 2 diabetes, a current target of wellness programs, is expected to generate rising costs, accounting for almost 92 billion dollars in public and private health care spending in 2003.¹⁰⁵ About 6.5 percent of Americans over age 20 have diabetes,¹⁰⁶ which is now the sixth leading cause of death in the U.S.¹⁰⁷ The federal government pays about 61 percent (\$77 billion) of national health care expenditures for diabetes treatment, most through Medicare (\$61 billion).¹⁰⁸ In general, chronic diseases and disabilities are more prevalent among populations who are low income, uninsured, or

101. See Catherine Hoffman, Dorothy Rice & Hai-Yen Sung, *Persons with Chronic Conditions: Their Prevalence and Costs*, 276 J. AM. MED. ASS'N 1473 (1996) (reporting that 76% of direct medical care costs in the U.S. are for chronic conditions); Martin Sipkoff, *Health Plans Begin to Address Chronic Care Management*, MANAGED CARE MAG., Dec. 2003, 24, 25 (reporting approximately 78% of health care spending is on behalf of individual's with chronic conditions).

102. SARA COLLINS ET AL., THE COMMONWEALTH FUND, HEALTH COVERAGE FOR AILING BABY BOOMERS, PUBL'N NO. 884 (Jan. 2006) *available at* http://www.commonwealthfund.org/usr_doc/884_Collins_hlt_coverage_aging_baby_boomers.pdf?section=4039.

103. National Center for Health Statistics, HEALTH, UNITED STATES, 2006 42 (2006); *available at* [http://www.cdc.gov/nchs/data/06.pdf#088](http://www.cdc.gov/nchs/data/hus/06.pdf#088) (last visited July 16, 2007).

104. *Id.* at 42.

105. MARSHA GOLD ET AL., STUDY OF FEDERAL SPENDING ON DIABETES: AN OPPORTUNITY FOR CHANGE 1, 21-22 (Mathematica Policy Research, Inc., June 2007) (monograph report of study also finding that the federal government expenditures on diabetes care accounted for "12 percent of the \$645 billion in total federal health spending" in 2005), *available at* <http://www.mathematica-mpr.com/publications/PDFs/FederalSpending.pdf>.

106. Catherine C. Cowie et al., *Prevalence of Diabetes and Impaired Fasting Glucose in Adults in the U.S. Population: National Health and Nutrition Examination Survey 1999-2002*, 29 DIABETES CARE 1263, 1265 tbl. 1 (2006).

107. Melanie P. Heron & Betty L. Smith, *Deaths: Leading Causes for 2003*, 55 (10) NATIONAL VITAL STATISTICS REPORTS 1, 7 (Mar. 15, 2007) (reporting 74,214 deaths from diabetes in 2003, the latest year for which final data were available); *available at* http://www.cdc.gov/nchs/data/nvsr/nvsr55/nvsr55_10.pdf.

108. *Id.* at 21.

covered by Medicaid or Medicare (including the elderly), than among those with commercial insurance.¹⁰⁹ This suggests that government has a larger financial stake in reducing the cost of diabetes and other chronic conditions than the private sector.¹¹⁰ The Centers for Medicare and Medicaid and presidential candidates are already emphasizing disease prevention over expanding insurance coverage.¹¹¹ If these efforts do not reduce costs, government may consider more direct measures to ensure compliance with health standards, such as mandatory participation in wellness programs.¹¹²

Wellness programs also depart from social solidarity by targeting risk factors that are more prevalent among disadvantaged populations than among those of higher socio-economic status. Health status is strongly

109. Services for people with disabilities account for a disproportionately large share of Medicaid spending. Anna Sommers & Mindy Cohen, *Medicaid's High Cost Enrollees: How Much Do They Drive Spending?* 6, 8 (The Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, Issue Paper 7490, March 2006), available at www.kff.org/medicaid/upload/7490.pdf (3.4% of all Medicaid enrollees were institutionalized and accounted for 31.6% of expenditures; non-institutionalized enrollees with disabilities represented 14.2% of enrollees and 30.6% of expenditures).

110. See Linda Blumberg & John Holahan, *Government as Reinsurer: Potential Impacts on Public and Private Spending*, 41(2) INQUIRY 130 (2004). See also Ron Z. Goetzel et al., *Can Health Promotion Programs Save Medicare Money?*, 2(1) CLINICAL INTERVENTIONS IN AGING (2007) (concluding that well-designed health promotion programs for older people could save Medicare money). But see *The Care of Patients with Severe Chronic Illness: A Report on the Medicare Program by the Dartmouth Atlas Project* (John E. Wennberg & Elliott S. Fisher eds., 2006) (finding that Medicare could reduce chronic care costs by up to 30% by reducing the variability and inconsistency of services provided), available at http://www.dartmouthatlas.org/atlas/2006_Chronic_Care_Atlas.pdf

111. Centers for Medicare and Medicaid Services, Senior Risk Reduction Demonstration, www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/Senior_Risk_Reduction_Solicitation.pdf (experimental program of health promotion services for Medicare beneficiaries) (last visited Mar. 1, 2008); Joshua T. Cohen et al., *Does Preventive Care Save Money? Health Economics and the Presidential Candidates*, supra note 70; David S. Broder, *A Route to Better Care*, WASH. POST at B7, June 3, 2007 (describing the candidates' statements). See also West Virginia Medicaid Member Agreement, www.wvdhhr.org/bms/oAdministration/bms_admin_WV_SPA06-02_20060503.pdf (tiered benefit packages based on compliance with health goals).

112. See *Anderson v. City of Taylor*, 2006 U.S. Dist. LEXIS 38075 (E.D. Mich. 2006) (city fire department's mandatory fitness program, requiring employees to submit to blood draws to check cholesterol levels, was an unconstitutional search under the Fourth Amendment). See generally SYLVIA N. TESH, *HIDDEN ARGUMENTS: POLITICAL IDEOLOGY AND DISEASE PREVENTION POLICY* 46 (1988) (arguing that state laws targeting individual conduct were prompted by a need to reduce health care costs or to lower mortality rates); DEBORAH LUPTON, *THE IMPERATIVE OF HEALTH: PUBLIC HEALTH AND THE REGULATED BODY* (1995).

correlated with income.¹¹³ Chronic conditions are more common among lower income populations.¹¹⁴ Diabetes disproportionately affects African Americans, Hispanics, Native Americans, and Alaska Natives.¹¹⁵ Smoking is also more prevalent among lower income groups.¹¹⁶ Thus, the people most likely to be subject to wellness program requirements may be those who need insurance the most and can least afford higher costs.¹¹⁷ While such groups may benefit from the improved health promised by such programs, their circumstances raise questions about whether their participation is truly voluntary.

Risk factors that wellness programs target can be seen as conditions for which society holds individuals personally responsible. Such conditions change as science identifies new sources of risk and society alters its norms of behavior.¹¹⁸ For example, smoking moved from a relatively common habit to pariah status in a few decades.¹¹⁹ The fact that obesity is now called an epidemic suggests little public tolerance for the overweight.¹²⁰ Diabetes,

113. See INSTITUTE OF MEDICINE, COMMITTEE ON THE CONSEQUENCES OF UNINSURANCE, *A SHARED DESTINY: COMMUNITY EFFECTS OF UNINSURANCE* (2003); SOCIAL DETERMINANTS OF HEALTH (Michael Marmot & Richard G. Wilkinson eds., 1996); RICHARD G. WILKINSON, *UNHEALTHY SOCIETIES: THE AFFLICTIONS OF INEQUALITY* (1996); National Center for Health Statistics, *HEALTH, UNITED STATES*, 2006, at 32-41 (2006).

114. National Center for Health Statistics, *HEALTH, UNITED STATES*, 2006, at 42 (2006); M.K. Islam et al., *Social Capital and Health: Does Egalitarianism Matter? A Literature Review*, 5 INT. J. EQUITY HEALTH 3 (2006); Mererdith Minkler et al., *Gradient of Disability Across the Socioeconomic Spectrum in the United States*, 355 N. ENGL. J. MED. 695 (2006).

115. GOLD ET AL., *STUDY OF FEDERAL SPENDING ON DIABETES*, *supra* note 105 at 1.

116. See Elizabeth M. Barbeau et al., *Working Class Matters: Socioeconomic Disadvantage, Race/Ethnicity, Gender, & Smoking in NHIS 2000*, 94 AM. J. PUB. H. 269 (2004) (reporting smoking is associated with working class jobs, low educational levels, and low income).

117. See Shiriki Kumanyika, *Obesity, Health Disparities, and Prevention Paradigms: Hard Questions and Hard Choices*, 2 PREVENTING CHRONIC DISEASE 1, 6 (Oct. 2005), available at www.cdc.gov/pcd/issues/2005/oct/05_0025.htm (arguing that it is unfair “to put the burden entirely on consumers to foster the shift in the demand-supply curves that relate to obesity, particularly for consumers in disadvantaged communities where the range of choices may be especially unfavorable and where most of the economic and political forces are far beyond their personal control”).

118. See generally ARTHUR J. BARSKY, *WORRIED SICK: OUR TROUBLED QUEST FOR WELLNESS* (1988) (arguing that as population health improves, Americans focus on lesser risks).

119. See SMOKING POLICY: LAW, POLICY & CULTURE 3-21 (Robert L. Rabin & Stephen D. Sugarman eds., 1993) (describing how public perceptions of personal responsibility for risk creation affect policy choices).

120. See Alison A. Hedley et al., *Prevalence of Overweight and Obesity Among US Children, Adolescents, and Adults, 1999-2000*, 291 JAMA 2847 (2004). But see Katherine

once considered out of anyone's control, also appears to be moving into the realm of personal responsibility. One might ask whether wellness programs will target other health risk factors, such as job stress and shift work.¹²¹

It is instructive to examine the conditions that are not (yet) considered suitable for personal responsibility. Among the health factors on which HIPAA prohibits discrimination is "evidence of insurability," which is defined to include "(i) conditions arising out of acts of domestic violence; and (ii) participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities."¹²² Victims of domestic violence may be encouraged to seek medical care (and obtain help) if they are not charged higher premiums. It is not clear whether sports enthusiasts use less medical care or less costly care than people with chronic diseases.¹²³ One might suspect that their exclusion from risk calculations is based more on social preference than on financial considerations. Making sure that victims of injuries are covered for medical care seems like simple justice, even if they assume the physical risk of injury. But, then, why single out other conditions, especially those that are less likely to be voluntarily assumed? The most plausible reason would be the comparative cost of coverage. Yet, if cost is the real reason, then any comparably expensive condition, regardless of how acquired, should be treated in the same manner.¹²⁴ Of course that would return the entire enterprise to classifications based on health risks.

M. Flegal et al., *Excess Deaths Associated with Underweight, Overweight, and Obesity*, 293 JAMA 1861 (2005) (finding obesity, but not overweight, associated with excess mortality).

121. See Ichiro Kawachi, *Injustice at Work and Health: Causation or Correlation?*, 63 OCCUP. ENVIRON. MED. 578 (2006) (analyzing the literature); Bruce S. McEwen, *Protective & Damaging Effects of Stress Mediators*, 338 NEW ENG. J. MED. 171 (1998) (explaining the physiologic response to stress and its links to obesity and hypertension).

122. 26 C.F.R. § 54.9802-1(f); 29 C.F.R. § 2590.702(f); 45 C.F.R. § 146.121(f).

123. See, e.g., *List of Top 10 Summer Sports with Most Injuries Provides Warning for Olympic Enthusiasts*, MEDSCAPE MED. NEWS, Sept. 1, 2000, <http://www.medscape.com/viewarticle/412143> (listing the top 10 summer recreational activities, with number of injuries, and total costs of injury, including medical, legal and other costs: Basketball (1,633,905; \$19.7 billion); Bicycles (1,498,252; \$28.6 billion); Baseball (492,832; \$6.6 billion); Soccer (477,647; \$6.7 billion); Softball (406,381; \$5.1 billion); Trampolines (246,875; \$4.1 billion); Inline Skating (233,806; \$4.2 billion); Horseback riding (196,260; \$4.9 billion); Weightlifting (189,942; \$2.7 billion); Volleyball (187,391; \$2.1 billion).

124. See Gar L. Olin & Jeffrey A. Rhoades, *The Five Most Costly Medical Conditions, 1997 and 2002: Estimates for the U.S. Civilian Noninstitutionalized Population*, Medical Care Expenditure Panel Survey Statistical Brief No. 80 (AHRQ, May 2005).

The absence of empirical support for distinguishing among conditions on the basis of costs and savings suggests that wellness programs may rely on unstated, perhaps unrecognized, bias against disadvantaged groups of people. There is a remarkable lack of empathy for people who are believed to be personally responsible for their medical conditions. For example, when asked to choose among seven options for reducing health care costs, 41 percent of people in a Sacramento (California) Healthcare Decisions discussion group chose “requir[ing] patients to pay higher rates if they do not follow medical advice that will keep them healthier”.¹²⁵ Similar attitudes can be seen in the policies of private organizations that refuse to hire individuals who smoke or are overweight. It is not clear whether such attitudes reflect assumptions that such behaviors and conditions generate higher costs of care or prejudice against certain behaviors and conditions. In either case, they encourage segmenting the population on the basis of health risks not only in insurance pools, but also in society at large.

III. CONCLUSION

The peculiarly American mix of entitlement and personal responsibility in today’s health reform proposals may be evidence of our ambivalence about social solidarity and personal responsibility for health. It may also mask deep divisions in beliefs about whether society or the individual ought to be responsible for health. Trying to have it both ways may make it impossible to agree on sustainable reform.

What is missing from current health reform debates is serious discussion of the role of insurance in defining responsibility for health. Is insurance a way to spread specific risks or a mechanism for financing health care for all? The use of market-based private insurance to provide universal access to care has encouraged reforms based on actuarial fairness, which make everyone responsible for his own risks. A focus on medical care costs confuses the use of insurance with the purchase of consumer goods. Attempts to cabin the cost of medical services by selectively inserting elements of risk-based cost-sharing into insurance policies chip away at the general goal of universal coverage. Increased cost sharing

125. Marjorie Ginsburg, *Rearranging the Deck Chairs*, HEALTH AFF. Web Exclusive w537, w539 (Oct. 24, 2006), available at <http://content.healthaffairs.org/cgi/reprint/25/6/w537> (the 3 options with more support were: restricting coverage of treatment that is not effective or is not critical for basic functioning and longevity, and limiting the use of expensive care with little benefit.).

encourages the belief that health is the personal responsibility of individuals, and not the responsibility of all society.

So far, increased cost sharing has been applied selectively, like redlining. People are slotted into the actuarial fairness side of the equation ostensibly for reasons of public health or social costs. But, an underlying motivation may be prejudice against historically disenfranchised groups. Combining wellness programs with insurance tends to disadvantage those most in need of assistance, undermining social solidarity. In the long run, people may be excluded not only from affordable premiums, but also from jobs or government services and benefits. In the absence of a defensible standard for selecting the conditions subject to higher payments, there is no principled limit to the scope of personal responsibility for one's health. If the standard is cost, then efforts to insert personal responsibility for health into social insurance reforms may presage the return to an era in which everyone was responsible for his own costs. After all, the original argument for coverage based on cost was actuarial fairness.

Alternatively, if services to prevent illness and promote health and fitness become an accepted part of health insurance coverage, the role of insurance may be converted from risk spreading into financing personal services. In such circumstances, it will be difficult to place any boundaries on the demand for services or their costs. If preventive measures push expensive illness to later ages, then the federal government will have a strong incentive to bring younger, healthier people into its risk pool to spread the costs of the population it finances. That case would produce a final paradox: efforts to increase personal responsibility may ultimately yield a form of government-sponsored social insurance.

ADAM, MARTIN AND JOHN: ICONOGRAPHY, INFRASTRUCTURE, AND AMERICA'S PATHOLOGICAL INCONSISTENCY ABOUT MEDICAL INSURANCE

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INTRODUCTION

Following the ongoing health care and insurance debate, which has once again moved toward center stage in American politics, one might

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In this article, I shall use the terms "medical insurance" and "health insurance" interchangeably. But my preferred term (in contrast that of most everybody else) is medical insurance. What is popularly and euphemistically labeled health insurance of course does not assure health. One can be fully covered and experience horrendous health. Similarly, coverage does not assure that medical care received will be adequate, competent, or successful (no matter how adequate or competent). More precisely, what we generally label health insurance is simply insurance that provides coverage for medical care expenses (however defined and restricted under the terms of a medical insurance policy). As becomes apparent in this article, I find the nomenclature unfortunate in that it helps to feed the subconscious misconception that people have some significant control over their own health. The best we can do is to reasonably maximize sound preventive care and assure that when adverse health events strike, the victim will be accorded reasonable medical care without regard to personal wealth.

understandably get the impression that the most important names in the area are politicians such as Hillary Clinton, Barack Obama, John Edwards, John McCain, or Mitt Romney.¹ Similarly, public intellectuals and pundits

1. All of these persons are, of course, presidential candidates who have each proposed various solutions for the perceived deficiencies of American health care and medical insurance. Democrats Clinton, Obama and Edwards have suggested quite similar plans modeled to some degree upon the mandated private coverage plan adopted by Massachusetts in 2006. Republicans McCain and Romney, have proposed less regulatory and government interventionist models relaying primarily on tax credits and incentives. See Farhana Hossain, *Where The Democrats Stand/Where the Republicans Stand*, NEW YORK TIMES, Sun., Dec. 30, 2007 at 14-15. See, e.g., John Edwards, *Building one America – through tax-funded health care*, LAS VEGAS REVIEW, Jan. 18, 2008, at 9B, col. 1. None of the major candidates has proposed a single payer plan, in spite of earlier predictions to the contrary. See, e.g., Fred Bannister, *November Is Coming And Single-Payer Proposals Could Follow*, NAT'L UNDERWRITER (Life & Health ed.), June 5, 2006, 27. As discussed herein, this is largely a reflection of the success with which market-based ideology favoring private insurers has dominated the public policy debate. See Cynthia Crossen, *Before WWI Began, Universal Health Care Seemed a Sure Thing*, WALL ST. J., April 30, 2007, B1, col. 1.

Ironically, Romney as Governor of Massachusetts supported that state's plan, which is quite similar to the major Democratic initiatives, albeit after opposing some provisions sought by the legislature, which overrode his veto before he signed the final bill into law. See Sally C. Pipes, *Intensive Care for RomneyCare*, WALL ST. J., Feb. 26, 2007, A19, col. 3 (CEO of conservative policy institute critical of Massachusetts plan identified with Romney); Steve LeBlanc, *Mass. House Overrides Gov. Romney Veto of Health Care Fee*, INS. J., April 26, 2006, available at www.insurancejournal.com/news/east/2006/04/26/67613.htm (describing peculiar circumstances and limited nature of veto as well as Romney's overall support for and advocacy of the law); Edit., *Romney Care*, WALL ST. J., April 12, 2006, A14, col. 1 (identifying Romney as proponent of plan, which Journal criticized as failing to "measure up to the political and media hosannas.").

See also, David Leonhardt, *A Health Fix That Is Not a Fantasy*, N.Y. TIMES, April 12, 2006, at C1, col. 1 (praising Massachusetts plan as prudent compromise between Canadian-style system and status quo in U.S.); see also Steve Piontek, *O Massachusetts!*, NAT'L UNDERWRITER (Life & Health ed.), April 10, 2006 at 4;

Although Massachusetts has received the most attention, the past two years have seen a number of state-based initiatives to address a perceived shortage of sufficient medical coverage and federal failure to act. See Joanne Wojcik, *Drive to force health coverage gains traction, 18 states consider measures*, BUS. INS., May 29, 2006 at 11. See, e.g., Kevin Sack, *San Francisco to Offer Care For Every Uninsured Adult*, N.Y. TIMES, Sept. 14, 2007, A1, col. 1; *Kan. Governor Calls for Universal Health Care, Tax Cuts*, INS. J., Jan. 12, 2007, available at www.insurancejournal.com/news/midwest/2007/01/12/75813.htm; Tom Breen, *W. Va. Seeks Fix for Soaring Health Insurance Costs*, INS. J., Jan. 3, 2007, available at www.insurancejournal.com/news/southeast/2007/01/03/75544.htm; *Bredesen: Tennessee Health Plan 'Opposite' of Massachusetts*, CLAIMS GUIDES, April 19, 2006, available at www.claimsguides.com/news/southeast/2006/04/19/67413.htm. See also Kevin Freking, *Sen. Kennedy Urges Universal Health Plan, Solicits Recommendations*, INS. J., Jan. 11, 2007, available at www.insurancejournal.com/news/natioanl/2007/01/11/75809.htm.

such as David Broder, David Brooks, Paul Krugman (or at least the *New York Times* and *Wall Street Journal* editorial pages) come to mind.² Alternatively, health care scholars such as the instant Symposium participants or other health policy scholars such as Uwe Reinhardt, Troyen Brennan or Theodore Marmor, although not quite household words in most of the United States, are well known to even the casual traveler in the region and might be advanced as important figures in the debate.³

But these people, however accomplished, important or wise they may be, arguably have less to do with the ongoing health insurance status quo in American than two dead men. The arguably most important people, at least iconographically, for American Health Care are John Wayne and Adam Smith.⁴ More precisely, the characteristics they have come to

See also Leonhardt, *supra*, at C1, col. 1 (“To a lot of thoughtful people, the only way to fix the health insurance crisis is to get the federal government to cover everyone. Britain, Canada, Japan and a number of other rich countries do so, and they each spend less many on health care than this country does. They also don’t have major companies, like General Motors, flirting with bankruptcy in large part because of the cost of health benefits. It is a pretty good argument, but it has an undeniable flaw. There is almost no chance of universal coverage happening anytime in the foreseeable future. Health insurers made \$100 billion in profits last year, and industries of that size are just not legislated out of business.”).

2. Broder, Brooks, and Krugman are all syndicated columnists and authors who frequently write on public policy and health care issues. *See, e.g.*, David S. Broder, *Health-care hybrid connects with officials*, SACRAMENTO BEE, May 1, 2006, available at www.sacbee.com/content/opinion/story (specifically commenting on Romney’s role in Massachusetts). Although faceless, the editorial pages of the *Times* and the *Journal*, as well as those of other major American newspapers, arguably are the leading public intellectuals in the health care debate and politics generally.

3. Reinhardt is a well known economist and health care expert at Princeton. Brennan teaches at Harvard Medical School and writes frequently on health care issues. Marmor, a similarly well-known author, is professor of politics, public policy and law at Yale University. *See, e.g.*, Aaron S. Kesselheim & Troyen A. Brennan, *The Swinging Pendulum: The Supreme Court Reverses Course on ERISA and Managed Care*, 5 YALE J. HEALTH POL’Y & ETHICS 451,451 (2005); Troyen A. Brennan, et al., *Identification of Adverse Events Occurring During Hospitalization*, 112 ANNALS INTERNAL MED. 221, 221 (1990); Uwe E. Reinhardt, *The Economist’s Model of Physician Behavior*, J.A.M. MED. ASS’N, Vol. 281, No. 5, Feb. 3, 199 at 462; Reinhardt, *Reforming the Health Care System: The Universal Dilemma*, 19, AM. J. L. & MED., 21, 21 (1993); Theodore Marmor, *Wanting It All: The Challenge of US Health System Reform*, 55 KAN. L. REV. 1137, 1137 (2007); Theodore R. Marmor, *How Not to Think About Medicare Reform*, 26 J. HEALTH POL. POL’Y & L. 107 (2001).

4. Other now-dead men, many of them largely anonymous, have of course also played a key role because of past decisions that shaped the current health care status quo. *See* Timothy Stolfus Jost, *Is Health Insurance a Bad Idea? The Consumer-Driven Perspective*, 14.2 CONN. INS. L.J. 377 (2008) (hereinafter Jost, *Bad Idea?*) (noting tax

embody and personify in the historical and public mind drive much of the reflexive thinking about American health care and medical insurance – largely in unfruitful directions. A third long-deceased icon personifies a different vision, but one that has never taken center stage in the medical insurance debate.

John Wayne needs little introduction, even to the members of Generations X & Y. His movies, most of them westerns, continue to populate cable movie channels. More than thirty years after his death, he continues to be the paradigmatic representation of the myth of American rugged individualism and self-sufficiency.⁵ Under the Wayne model, the individual is both charged with controlling his own destiny and expected to succeed in doing so, in spite of long odds, with little or no help from others (save or a possible gunslinging sidekick or two). This archetype is expected to engage in effective self-help without hesitation (or guilt)(what’s a few dead bodies in the service of a greater cause?), complaint, or self-pity. Even things like being shot are only minor setbacks to this archetype. Certainly, acute or chronic illness would not break his stride and he would not expect government to provide him any health care safety net.

Adam Smith, who needs perhaps even less introduction to readers of a scholarly journal, was the Eighteenth Century Scottish philosopher and economist who persuasively argued that largely unregulated private

subsidies for particular types of medical insurance); David A. Hyman, *Health Insurance: Market Failure or Government Failure?*, 14.2 CONN. INS. L.J. 307 (2008) (hereinafter Hyman, *Government Failure?*) (noting role of World War II wage and price controls, 1943 IRS Ruling, and 1954 legislation, and labor union demands encouraging use of employer-provided medical insurance as fringe benefit that was not taxed when received by workers but could be deducted by employers as a business expense). *Accord*, John V. Jacobi, *Consumer-Directed Health Care and the Chronically Ill*, 38 U. MICH. J.L. REFORM 531, 531 (2004) (addressing more recent “path to consumer-driven health care”); David. A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL’Y & ETHICS 23, 25-26 (2001) (describing development of employer-provided group insurance in more detail). As Oliver Wendell Holmes famously observed, a page of history is worth a volume of logic and outcomes are to a large extent path dependent. *See*, *New York Trust Co. v. Eisner*, 256 U.S. 345, 349 (1921).

5. Typically, Wayne portrayed a strong, silent type good guy who when pressed would fight (with quite deadly force) for his rights and those of anyone oppressed by the bad guys de jour in his movies, who where most often ordinary criminals or business thugs along with the occasional Indian (Wayne would never have used the words “native American”) renegade (e.g., *The Comancheros*). In occasional forays outside the Western movie genre (e.g., *The Quiet Man*), Wayne largely portrayed the same character, albeit unarmed and less prone to violence.

markets were the key to economic growth and prosperity. According to Smith, the pursuit of private gain by individuals and entities throughout society would, as if guided by an “invisible hand,” lead to the optimal allocation of goods and services. This, in turn, would create an optimally efficient state of affairs and maximum aggregate wealth for society.⁶

Implicit in Smith’s assessment, but underemphasized relative to wealth, was the inevitability that some market participants would fare better than others. A tacitly paid price for greater overall wealth and economic growth was relative poverty and failure for some. During much of post-Smith history, the “fallout” from his market-oriented approach, which was largely accepted in Europe and North America, was treated as a necessary evil required to obtain the benefits of a vibrant mercantile system.

During the Twentieth Century, politics and government moved to soften the edges of inequality through social welfare programs and infrastructure designed to foster greater equality of opportunity (e.g., public schools). In addition, it became recognized that on occasion the invisible hand faltered and market failure or imperfection justified regulatory correction.⁷ Thus, notwithstanding the demi-god status of Smith (to the intellectual public) and Wayne (to the general public), there is a strong social justice strand in American thought that emphasized communitarian norms such as equal access, solidarity against life’s greatest threats, and assistance to the less fortunate. Arguably, no particular person epitomizes this school of American thought to the degree Wayne embodies rugged individualism and Smith market efficiency. As this article argues, that’s part of the problem: the iconic status of rugged individualism and market efficiency is so firmly established in the American psyche that it works to the occasionally unfortunate detriment of social justice and communitarian

6. See ADAM SMITH, *THE WEALTH OF NATIONS* (Prometheus Books 1991) (1776).

7. This revision to the pure laissez faire or invisible hand ideology that dominated the U.S during the late 19th Century is most associated with Franklin Delano Roosevelt’s “New Deal,” which established significant regulatory infrastructure for many business activities. However, the administrations of predecessor Presidents Theodore Roosevelt and Woodrow Wilson had also made considerable strides in this direction, as had Congress. After Republican challenges by Wendell Willkie and Thomas Dewey to Franklin Roosevelt and Harry Truman, respectively failed, many of the basic New Deal principles and structures were accepted, at least tacitly, by all major political actors, including Dwight Eisenhower, who succeeded Truman as president. See PAUL KRUGMAN, *A LIBERAL CONSCIENCE* Chs. 1-3 (2007); Suzanne Bilyeu, *FDR: how he changed America – and still affects your life today; no President has had as great an impact on everyday life in America*, N.Y TIMES UPFRONT, Jan. 14, 2008, p. 24.

values. American resistance to a government-administered single-payer system of medical insurance is one of those unfortunate occasions.

Perhaps the closest thing to a Wayne or Smith-like secular icon embodying social justice and community compassion values is Martin Luther King, although others might prefer Abraham Lincoln, Franklin Delano Roosevelt, Robert Kennedy, some other progressive politician, military leader (George C. Marshall or Dwight Eisenhower would be credible candidates), or social welfare advocate (e.g., Marian Wright Edelman) as the symbol of this segment of national thought.⁸

8. To (I hope) state the already known: Lincoln was President of the United States during the Civil War; Kennedy was Attorney General of the United States and U.S. Senator from New York during the 1960s; Army General Marshall was Chairman of the Joint Chiefs of Staff during World War II and the driving force behind the Marshall Plan to rebuild Europe after the War; Army General Eisenhower was Supreme Allied Commander in Europe during the War and later President; Edelman is founder of the Children's Defense Fund (and a sufficiently iconic figure that Hillary Clinton took pains to mention her status as Clinton's first employer after law school during the Democratic candidates' debate in South Carolina on Jan. 21, 2008). Certainly, the author of *Abraham, Martin and John* saw Lincoln and Kennedy as united in common cause with King as well as by their violent death's form assassin's bullets. See introductory note, *supra*.

In attempting to identify a personification of social justice and communitarian values, I am specifically overlooking religious figures. My selection of King as icon for the social justice school of American thought could be viewed as a religious figure in that King was a Protestant Minister and frequently invoked religious themes in his speeches. See Sarah Vowell, *Radical love gets a holiday*, N.Y. TIMES, Jan. 22, 2008, A19, col. 1 (noting King's use of biblical themes and comparison of his speeches, particularly "I Have a Dream" speech, to Jesus's Sermon on the Mount). See, e.g., Martin Luther King, Jr., *Letter From Birmingham City Jail* (April 12, 1963) (making repeated religious references to Jesus Christ and other religious figures in writing to addressees "as a fellow clergyman and a Christian brother" hoping to find them "strong in the faith"), reprinted in JAMES M. WASHINGTON (ED.), *A TESTAMENT OF HOPE: THE ESSENTIAL WRITINGS AND SPEECHES OF MARTIN LUTHER KING, JR.*, 289 (1986) and (perhaps more accessible to the legal profession) STEPHEN N. SUBRIN, MARTHA L. MINOW, MARK S. BRODIN & THOMAS O. MAIN, *CIVIL PROCEDURE: DOCTRINE, PRACTICE AND CONTEXT* 149 (2d ed. 2004). See also *Walker v. City of Birmingham*, 388 U.S. 307 (1967) (reprinting as Appendix King's speech in connection with efforts to stage protest march) ("We believe in a system of law based on justice and morality.").

In spite of this, I view King as primarily a socially secular figure. Certainly, he tried hard to be inclusive and non-denominational even as he invoked religious themes. For example, his Letter from a Birmingham Jail takes pains to include reference to his "Christian and Jewish brothers" and he specifically discusses the Jewish philosopher Martin Buber.

More important, King's legacy today is a secular one of racial and social justice founded on rational concepts of fair treatment of individuals and retains little of its once more overtly religious air or rhetoric. As testament, I am writing this on the national King holiday (Monday, Jan. 22, 2008), one widely observed in an overwhelmingly secular

In addition, there is a “professionalism” paradigm for conceiving health care that competes with an economic/market competition model, a social justice/rights-based model, and an institutional model.⁹ Peter Jacobson has characterized the field as reflecting “an ongoing struggle between market proponents (a consumer-driven health care system), proponents of a social justice model (largely governmentally determined), and medical professionals” with the social justice model in at least temporary ebb while “the real struggle for doctrinal supremacy in health law is between the market and professional models.”¹⁰

Interestingly and ironically, Adam Smith can perform double duty on as a representative of the professionalism model as well. Smith supported professional self-regulation (and substantial remuneration for

manner. In a widely televised CNN Democratic presidential earlier in the day, there was considerable reference to King, including a concluding Wolf Blitzer question regarding which candidate King would endorse were he still alive (and not assassinated on April 4, 1967 in Memphis, Tennessee, an event noted in the 1983 U2 song *Pride in the Name of Love*), further testament to King’s place in secular popular culture). All of the discussion was secular and did not mention King’s religious roots or rhetoric. See also *Martin Luther King, III and John Edwards*, email from Edwards for President campaign, Jan. 21, 2008 (Democratic presidential candidate attempts to use favorable comments by King’s eldest son to win votes and contributions in secular manner).

Perhaps the ultimate proof of King’s secular status, albeit kitschy and perhaps offensive to veterans of the civil rights movement, is an email I received on January 21, 2008 announcing a “Martin Luther King Day Special” on continuing legal education through which an attorney could pay “only \$199 to fulfill your California MCLE” as part of the vender’s desire to “celebrate [King’s impact on American life.” See *Martin Luther King Day Special: Only \$199 to Fulfill Your Entire California MCLE*, Law.com CLE Center, Jan. 21, 2008. Just as George Washington and Abraham Lincoln became associated with winter furniture sales, King’s legacy has been appropriated, in at least some part, by commercial interests. Once again, the Smith/Wayne iconography of market and individual consumerism exhibits an imperialism that attempts to impose itself on social justice and professionalism.

9. See Peter D. Jacobson, *Health Law 2005: An Agenda*, J. L. MED. & ETHICS 725, 734-35 (Winter 2005), quoting LAWRENCE O. GOSTIN & PETER D. JACOBSON, *LAW AND THE HEALTH CARE SYSTEM* (2005). See also PETER D. JACOBSON, *STRANGERS IN THE NIGHT: LAW AND MEDICINE IN THE MANAGED CARE ERA* 212 (2002).

10. See Jacobson, *supra* note 9, at 735. For examples of a social justice perspective on health care issues, see, e.g., Dayna Bowen Matthew, *Assessing Patient Protection Laws*, 47 ST. LOUIS U. L.J. 299, 302 (2003); Dayna Bowen Matthew, *The “New Federalism” Approach to Medicaid: Empirical Evidence that Ceding Inherently Federal Authority to the States Harms Public Health*, 90 KY. L.J. 973, 934 (2002); Dayna Bowen Matthew, *Controlling the Reverse Agency Costs of Employment-Based Health Insurance: Of markets, Courts, and a Regulatory Quagmire*, 31 WAKE FOREST L. REV. 1037, 1502 (1996) (also making economic and behavioral analysis of issues).

professionals) in order to achieve high professional standards and quality that would in turn redound to the benefit of society.¹¹ In effect, a good part of the current health care debate can be characterized as one waged by the ghosts of the Market Smith and the Professionalism Smith.

Regarding the competing paradigms outlined by Jacobson, I am arguably adding rugged individualism and personal responsibility to the list rather than treating it solely as a subset of the economic/market model. On the issue of institutional competence, I accept Jacobson's assessment that this is an important framing device in debating health policy, one that (as discussed later in this article) weighs in favor of a greater government role in providing medical coverage. But institutional competence as a school of thought is less prominent in the American psyche. No particular icon of institutional competence emerges in national folklore, although it is perhaps personified to an extent by FDR, who popularized government as a competent institution to respond to economic and social concerns and to provide a safety net and springboard for the citizenry. Perhaps a better human representation of the institutional aspect of health policy debate would be Lyndon Johnson, whose political skill and electoral power in the wake of his 1964 landslide over Barry Goldwater brought about Medicare.¹²

The trio of Smith, Wayne and King, of course, played no direct role in the development of health care and medical insurance policy. But the perceptions and attitudes they represent have driven much of American

11. See SMITH, *supra* note 6, at 111.

We trust our health to the physician; our fortune and sometimes our life and reputation to the lawyer and attorney. Such confidence could not safely be reposed in people of a very mean or low condition. Their reward must be such, therefore, as may give them that rank in the society which so important a trust requires. The long time and the great expence which must be laid out in their education, when combined with this circumstance, necessarily enhance still further the price of their labour.

Id. (spelling in original).

12. See Sonia M. Suter, *The Allure and Peril of Genetics Exceptionalism: Do We Need Special Genetics Legislation?*, 79 WASH. U. L.Q. 660, 725 n.297 (2001). Looking abroad, Otto von Bismarck, who as chancellor of Germany established social welfare programs in the late 19th Century would be a similarly apt representative, as would the political "fathers" of the health care systems in other European countries and Canada. See Lewis D. Solomon & Geoffrey A. Barrow, *Privatization of Social Security: A Legal and Policy Analysis*, 5 KAN. J.L. & PUB. POL'Y 9, 11 (1995).

opinion that does directly affect the long-running debate and attitudes toward the status quo and proposed alternatives. Because of Waynian rugged individualism, there is resistance to communal insurance programs, even to the point where the old bogeyman of “socialized medicine” remains a standard part of the stump speeches of at least Republican presidential candidates (at least during the primary season when preaching to the faithful).¹³ This strand of the American character has also given much rhetorical force to terms like “consumer-driven,” “ownership society,” “freedom,” and “choice.”¹⁴ Working in tandem with the rugged individualism ethos of “freedom,” Smithian fidelity to private markets makes even Democrats flinch from advocating a single-payer, government administered medical insurance system, although this is largely the norm in

13. See Mary Anne Bobinski, *The Health Insurance Debate in Canada: Lessons for the United States?*, 14.2 CONN. INS. L.J. 341 (2008) (“The very terms of the debate [in the U.S.] – ‘socialized medicine’ and ‘government bureaucrats’ – reveal more about the signposts of American political discourse than they do about the reality of the [Canadian] system they seek to describe”) (footnote omitted). Mitt Romney, in particular, has used the phrase as a criticism of the proposals of Democratic candidates notwithstanding his support for significant government intervention in the medical care market when he was governor of Massachusetts. See Broder *supra* note 2.

14. See Barry R. Furrow, *Access to Health Care and Political Ideology: Wouldn't You Really Have a Pony?*, 29 W. NEW ENG. L. REV. 405, 412 (2007) (“Americans love efficiency and consumer choice”).

As illustrated in Furrow's article, there is often a substantial tension between the goals of personal autonomy and the quality and availability of medical coverage. Furrow's primary target in that piece is Hyman, who provided the pony metaphor of choice-versus-health safety net in a cartoon published in an issue of the *Journal of Health Policy, Politics and the Law* focusing on the FTC's *Report on Health Care and Competition* for which Hyman was a primary author. *Id.* at 414. (characterizing market choice position on health care, including HSAs as “plausible in the abstract but flawed for too many Americans who need health care, yet still appealing to those ideologically blinded to the costs of the market in health care and the human waste generated by ideology ungrounded in complex reality”). In this Symposium, Jost and Mariner are not as directly in focused combat with Hyman (a role that perhaps falls to me) but they reflect a perspective akin to Furrow's. See also Timothy Stoltzfus Jost, *The Massachusetts Health Plan: Public Insurance for the Poor, Private Insurance for the Wealthy, Self-Insurance for the Rest*, 55 KAN. L. REV. 1091, 1092 (2007) (writing from perspective similar to Jost, *Bad Idea?*, *supra* note 4 (manuscript at 2-3)); David A. Hyman, *The Massachusetts Health Plan: The Good, the Bad, and the Ugly*, 55 KAN. L. REV. 1103 (2007) (writing from perspective similar to Hyman, *Government Failure*, *supra* note 4) (and apparently preferring Clint Eastwood to John Wayne as an icon of rugged individualism).

Canada and the Western European societies most analogous to the U.S.,¹⁵ societies that seem to be quite productive and free.

Pushing back, with mixed success, against these social and psychological forces (that also have great political and financial support from special interests such as private insurers and drug manufacturers) are the professionalism strand of Smith and King's social justice perspective. These push in largely the opposite direction, seeking universal, community-wide medical coverage and greater government involvement to achieve this goal.¹⁶

The iconic pull of market and individualism notions and personas is so strong that it has prevented full progression of health coverage in the U.S. and today supports a strong counter-revolution in the form of Health Savings Accounts (HSAs) and other types of allegedly "consumer-driven" health coverage as part of an "ownership" society.¹⁷ Despite increasing

15. In the field of eight Democratic hopefuls (Clinton, Obama, Edwards, Biden, Dodd, Richardson, Gravel and Kucinich) prior to the January 2008 Iowa caucuses, only Kucinich backed a government-administered single payer system. See Molly Ball, *Meet the Candidates: 10th in a Series*, LAS VEGAS REV.-J., Jan. 1, 2008, at B1.

16. As Hyman would undoubtedly note, the professionalism perspective receives substantial special interest support from doctors and to some extent from other medical providers. See, e.g., David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893 (2005). But unlike Hyman (at least as I read his work), I do not see physicians and other medical providers (hospitals, labs, diagnostic services, equipment makers) as uniformly in lockstep in their drive (strongly emphasized by Hyman) to extract more money from the pockets of patients or payers (be they government or private insurers). The relative interests and preferences of medical providers may well diverge. For example, hospitals might rationally conclude that they will do better under a private insurance regime than a government single payer regime of medical insurance. As discussed below (TAN 65-75, *infra*), I have a strong suspicion that this is the case given the degree to which private insurance has not in my view done as much to tamp down hospital charges as it has done to extract discounts from physicians.

17. See Jost, *Bad Idea?*, *supra* note 4 (observing trend but criticizing concept and current operationalization); Russell B. Cate, *Move Over Managed Care – Health Savings Accounts, Small Businesses, and Low Wage Earners: Cost, Quality, and Access*, 4 IND. HEALTH L. REV. 287, 288 (2007) (praising HSAs and consumer-driven movement generally); John A. Nyman, *Consumer-Driven Health Care: Moral Hazard, the Efficiency of Income Transfers, and Market Power*, 13 CONN. INS. L.J. 1, 17 (2006) (taking a critical stance); Amy B. Monahan, *The Promise and Peril of Ownership Society Health Care Policy*, 80 TUL. L. REV. 777, 777 (2006) (expressing interest in concept but finding current practice unlikely to accomplish goals of consumer-driven movement); Edward J. Larson & Marc Dettmann, *The Impact of HSAs on Health Care Reform: Preliminary Results After One Year*, 40 WAKE FOREST L. REV. 1087, 1123 (2005) (positing positive but not large impact of HSAs); Jacobi, *supra* note 4 (finding consumer-driven initiatives such as Health

evidence that America would be better off moving toward a single payer system similar to the Canadian-European models,¹⁸ political reality continues to serve up either market-based or hybrid systems that at best provide only halting progress and at worst resemble a private-public bureaucracy seemingly designed by Franz Kafka and Rube Goldberg.¹⁹

Savings Accounts apt for relatively inexpensive, predictable, routine medical treatment costs but not for chronic and catastrophic medical costs); Timothy S. Jost & Mark A. Hall, *The Role of State Regulation in Consumer-Driven Health Care*, 31 AM. J.L. & MED. 395, 395 (2005); Wendy K. Mariner, *Can Consumer-Choice Plans Satisfy Patients? Problems with Theory and Practice in Health Insurance Contracts*, 69 BROOK. L. REV. 485, 508 (2003) (expressing concerns regarding efficacy of consumer-driven initiatives for actual consumers); Comment, *Employee Driven Health Care: Health Savings Accounts, More Harm Than Good*, 8 U. PA. J. LAB. & EMP. L. 219, 236 (2005) (attacking the concept). See also Mark V. Pauly, Patricia Danzon, Paul Feldstein & John Hoff, *A Plan for 'Responsible National Health Insurance'*, HEALTH AFFAIRS, 5, 7 (Spring 1991), (early argument in favor of variant of consumer-driven approach much like mandated private insurance purchases of Massachusetts plan).

18. Studies consistently show that countries with government-administered national medical insurance have per capita health care costs of approximately half those in the United States and that by almost all measure, their populations are at least as healthy as Americans. See PAUL KRUGMAN, CONSCIENCE OF A LIBERAL 218 (2007) (2004 per capita health care spending in U.S. is \$6,102, as compared to \$3,165 in Canada, \$3,150 in France, \$3,043 in Germany, \$2,508 in Great Britain); Jost, *Bad Idea?*, *supra* note 4; Justin Lahart, *Rethinking Health Care and the GDP*, WALL ST. J., Jan. 25, 2007, at C1 (U.S. spends 16 percent of its gross domestic product on health care, as compared to much lower proportions for Germany (10.6 percent of GDP), France (10.5 percent), Canada (9.9 Percent), Italy (8.8 percent), the U.K. (8.4 percent), and Japan (8.0 percent) but “Americans don’t seem to be getting much for the money. In both France and Japan, the average life expectancy is higher than in the U.S., and the infant mortality rate is lower. This is true in most other [developed] countries . . .”). Accord, Uwe E. Reinhardt, Peter S. Hussey & Gerard F. Anderson, *U.S. Health Care Spending In An International Context*, 23 HEALTH AFFAIRS 10, 11 (2004); Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey & Varduhi Petrosyan, *It’s the Prices, Stupid: Why the United States Is So Different From Other Countries*, 22 HEALTH AFFAIRS 89 (2003) (contending that “[h]igher health spending but lower use of health services adds up to much higher prices in the United States than in any other [Organization for Economic Cooperation and Development] OECD [a/k/a/ developed] country.”) But see Bobinski, *supra* note 13 (manuscript at 7-8). (Canadian expenses recently rising more rapidly than in the past, reaching \$4,548 per capita and 10.3 percent of GNP in 2006); Patricia M. Danzon, *Hidden Overhead Costs: Is Canada’s System Really Less Expensive?*, 11 HEALTH AFFAIRS 21, 22 (1992). See also Troyen Brennan, *Transcribed Speech of Troyen Brennan*, 15 ANNALS HEALTH L. 339, Appendices B, C (2006) (U.S. health insurance premiums nearly doubled between 1999 and 2005, far outpacing both medical inflation and overall inflation).

19. The 1993 proposal of the Clinton Administration (dubbed “Hillarycare” by critics) provides perhaps the best example. Diagramming the plan resembled a Jackson Pollock painting. But other popular proposals such as the Massachusetts plan and those of the

This comment addresses the legacy of what I term the Wayne-Smith (market) mindset and its effect on the modern medical coverage debate, focusing in particular on several misconceptions, overstatements, and cognitive errors that have prevented the U.S. from embracing a modern, government-administered universal medical coverage along the lines of the Canadian-European model. These concepts too greatly dominate American views on the issue, obstructing progress toward a Canadian or European model that would dramatically improve the overall cost and quality of American medical care. A government-administered single-payer system more consistent with the Smith (professionalism) and King social justice models would provide more productive templates for expanding, improving, and streamlining United States medical care.²⁰

The legacy of uncritical acceptance of the Wayne-like individualism and Smithian world of omniscient markets include: the legal fictions that individuals consistently best know their own interests and can effectively shop for insurance coverage and medical care;²¹ the legal friction or tension

leading Democratic presidential candidates also contain considerable complexity. See SUSAN ESTRICH, *THE CASE FOR HILLARY CLINTON* 104 (2005).

20. I use the term “single-payer” both literally (I would prefer a program more like that of France or an expanded version of Medicare) and as a short-hand reference meaning a national government mandated system of public medical insurance even if in distribution multiple loci of payment are used. See Jost, *supra* note 14, at 1091 (“This model is often characterized as a single-payer model, although universal public coverage does not, of course, require a single payer. Many of the world’s social insurance programs in fact have multiple payers”).

Considering costs and benefits in totality, I operate with the premise that the quality of care increases if, on the whole, a higher quantum of competent medical service is provided throughout society. Thus, I would consider a system “better” if it served all people with B+ level care and eliminated noncoverage and reduced substandard care even if some persons who formerly received A+ or gold-plated care with shorter waiting times would have preferred the current system. Taking this broad view, there is almost no question that the Canadian and Western European systems are “better” than that of the U.S. See Bobinski, *supra* note 13, (“In the aggregate, the result is that Canadians fare better than Americans” and noting that as compared to Canadians, Americans “are one third less likely to have a regular medical doctors, one fourth more likely to have unmet health care needs, and more than twice as likely to forego necessary medicines.” (quoting Karen E. Lasser, *et al.*, *Access to Care, Health Status, and Health Disparities in the United States and Canada: Results of a Cross-National Population-Based Survey*, 96 AMER. J. PUB. HEALTH 1300, 1303 (2006)).

21. See TAN 27-53, *infra*. I realize I am using a modified version of the term “legal fiction,” which most commonly is used to describe a legal rule that, although demonstrably untrue as an empirical matter, is treated as true under the law in order to achieve a legal-social end.

between individualism and communitarian empathy;²² undue veneration of markets, failure to appreciate the current system's adverse pressures on medical professionals;²³ failure to realize the degree to which the evolved status quo already severely compromises market efficiency and medical professionalism;²⁴ and unduly credulous acceptance of the supposed efficiency of private insurance as a vehicle for fair cost control.²⁵

In addition, the body politic has paid insufficient attention to the manner in which private insurers have adversely impacted medical professionalism and the quality of care while at the same time failing to provide sufficient cost containment.²⁶ Assessing these aspects of the current debate leads to rejection of the supposedly consumer-driven approach and toward support for a national, government-administered single payer program as the preferred alternative to the private insurance mandates, markets and tax incentives largely suggested as the means of reforming the American status quo.

For example, the legal rule that a corporation is a "person" under the law for purposes of constitutional analysis is factually incorrect. The corporate entity is clearly not a human being. The law treats it, however, as if it was a human being for purposes of application of the Due Process Clause and other parts of the law. By contrast, the notion that people are more rational, energetic, ambitious, intelligent, consistent, and careful than they really are is a misconception of fact rather than a total rejection of the empirical world. In the real world, people are negligent more often, lazier, dumber, less rational, and more inconsistent than is assumed by defenders of the U.S. health care status quo or consumer-driven alternatives. But rather than labeling this a factual fiction, I term it a legal friction because it has become relatively hard-wired into much of the law reform and public policy discussion surrounding medical care and insurance issues and is in tension with empirical reality that would normally be more determinant of public policy outcomes.

22. See TAN 54-58, *infra*. This friction or tension is explored in Jost, *supra* note 4, and Wendy K. Mariner, *Social Solidarity and Personal Responsibility in Health Reform*, 14 CONN. INS. L.J. 199 (2008). Jost refers to the divide as one of solidarity-vs-individualism while Mariner speaks largely of a social solidarity-vs-personal responsibility dichotomy.

23. See TAN 84-89, *infra*.

24. See TAN 90-100, *infra*.

25. See TAN 59-76, *infra*.

26. See TAN 59-84, *infra*.

I. LEGAL FICTIONS AND LEGAL FRICTIONS

A. THE LEGAL FICTION OF THE CONSISTENTLY-RATIONAL,
EMPOWERED CONSUMER

In reality, of course, the strong American values of rugged individualism and preference for private markets are often compromised, so much so that we do not even appreciate the degree to which the America's secular church of public opinion has engaged in heretical behavior. For many Americans, there is already a largely government-run medical care system – the Veteran's Administration system of hospitals and medical care in that arena that is not much different from the socialized medical system of Great Britain. Similarly, we notice with some alarm when insurers and their executives earn high profits even if we are hesitant to raise taxes, stop potentially anticompetitive consolidation or take regulatory action that might impinge on the profitability of health insurers or health care providers. Most prominently, through programs like Medicare and Medicaid (and the Federal Employees Insurance Program), the government has become deeply involved in medical insurance notwithstanding purported American fidelity to private markets and minimalist regulation.

In general, however, the United States has largely resisted Canadian-European style universal health care and medical insurance out of deference to the mythology of rugged individualism and efficacy of markets. In addition, these perceptions have fueled collateral norms and beliefs that have impeded any move toward a national single payer approach to health insurance. First, there is what I regard as the erroneous legal fiction that people are more discerning about their health care and insurance choices than is actually the case. In addition, we operate under a legal fiction that to some extent a large percentage of persons afflicted with medical problems are themselves responsible for their plight through personal failure. Both of these presumptions, if not completely erroneous, are at least far more problematic than acknowledged.

First, the issue of whether prospective patients really know what is best for them regarding medical care and insurance coverage. A large amount of psychological research suggests that people in general are not nearly as good at decision-making as is commonly supposed. Rather than being consistently wise, calculating, rational decisionmakers, people are subject to a host of cognitive biases that may often warp their assessments. Among

them are self-serving bias, optimism bias, status quo bias, hindsight bias, and extremeness aversion.²⁷ In addition, various heuristic traits of humans govern their decisionmaking process, sometimes in ways that make for sub-optimal analysis. Among these are the availability heuristic, social influence, anchoring, and case-based decisions.²⁸ Further, people sometimes make irrational decisions because of loss aversion and the “mental accounting” of excessively compartmentalizing money rather than viewing it as fungible, which impedes good cost-benefit analysis.²⁹

In general, people are only able to focus on one or two salient factors at a time when making decisions. They are rational, but only have “bounded” rationality that is shaped to a large degree by the choices presented, the manner in which the choices are presented, and the overall context of the situation requiring a decision.³⁰ Thus, even under the best of circumstances, people are often not optimal decisionmakers. They are often more Britney Spears than John Wayne or Adam Smith.

This becomes particularly problematic regarding medical care and insurance because these situations seldom present optimal settings for sound decisionmaking. The process of seeking and evaluating medical care and advice is often complexity and usually unfamiliar to laypersons. Most people are not well educated about either medicine or insurance, both of which are complex. As a result, they will have inherent difficulty making assessments about competing medical care or insurance alternatives.

As Wendy Mariner has noted, there exist significant differences between ordinary consumers engaged in regular retail activity and health care patients. Consumers are active buyers while patients are often required to be more passive “recipients” of medical services (if they can afford the services). Consumer spending is more strictly limited by personal resources while patient expenditures, at least for the insured, are not strictly tied to patient wealth. Consumers tend to have something closer to bargaining equality with vendors while patients have “unequal

27. See Cass R. Sunstein, *Introduction* to BEHAVIORAL SCIENCE AND THE LAW (Cass R. Sunstein ed. 2000); Jeffrey W. Stempel, *Not-So-Peaceful Coexistence: Inherent Tensions in Addressing Tort Reform*, 4 NEV. L.J. 337, 350-51 (summarizing concepts in condensed fashion).

28. See Sunstein, *supra* note 27, at 5; Stempel, *Coexistence*, *supra* note 27, at 351-52.

29. See Sunstein, *supra* note 27, at 5; Stempel, *Coexistence*, *supra* note 27, at 353.

30. See BARRY SCHWARTZ, *THE PARADOX OF CHOICE: WHY MORE IS LESS* 19-20 (2004); Russell Korobkin, *Bounded Rationality, Standard Form Contracts, and Unconscionability*, 70 U. CHI. L. REV. 1203 (2003); Russell Korobkin, *The Efficiency of Managed Care, “Patient Protection” Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1 (1999).

skill and knowledge of health care” relative to medical providers. However, medical providers have at least a quasi-fiduciary duty to the patient while vendors ordinarily have no fiduciary duty to buyers (but often do have obligations sounding in statute, regulation or tort law). Most important, a standard issue consumer makes purchases “based on voluntary choice” while the medical patient seeks care “based on need.”³¹

Although they may have tools for mitigating the patients’ informational disadvantage relative to medical care providers and insurers (e.g., WebMD, word-of-mouth, local reputation),³² these hardly level the playing field for obtaining medical care. Particularly if a need for medical care arises suddenly, the consumer is effectively stripped of even the illusion of choice. In extreme cases (e.g., an auto accident that disables the consumer), the choice of medical care is made by others. Even when making conscious choices, the prospective patient is usually limited by insurance coverage and the treating physician’s hospital privileges as well as the availability of facilities. Once admitted to a hospital for care (which may take hours if arising unexpectedly, the patient is able to change venue only if he or she has picked up a few tips from watching *Prison Break*, *Escape from Alcatraz*, or similar media fare.

But the problems of shopping for doctors pale in comparison to the problems of shopping for insurance. Because many medical events are not serious, consumers have some chance to gain experience that they can deploy in obtaining medical care. For example, if the first doctor one sees is uninformed or unfriendly, the patient can go elsewhere for the next office visit (although this may be difficult in areas with a shortage of physicians

31. See Wendy K. Mariner, *Theory and Practice*, *supra*, note 17, at 495 fig.1.

32. Tools such as WebMD and a home copy of the Physician’s Desk Reference can be wonderful aides in managing one’s own medical care. But self-directed reading and study alone can of course not even approach the training and expertise of medical professionals. A consumer can become better informed about medical issues but will never be as discerning a consumer of medical services as she is of grocery stores, restaurants, or even more esoteric everyday fare such as auto repair.

Word of mouth and reputation are helpful but suffer a severe limitation in that the sources of this information usually suffer from the same limitations of expertise that make it difficult for the instant consumer. In particular, because of the complexity of medical care, consumers may evaluate medical providers by factors relatively unrelated to the quality of care. For example, a given medical provider may have an undeservedly good reputation because of friendly office staff, spacious facilities, and short waiting times even if the doctor is borderline incompetent as a diagnostician or unwilling to immediately prescribe useful treatment for fear running afoul of insurers. Conversely, a technically excellent physician may have only a so-so reputation because weak interpersonal skills or because she is a woman, member of a racial or ethnic minority, or of foreign origin.

where doctors are not taking new patients). Routine doctor visits, prescription fills, or diagnostic tests, although different than a trip to the supermarket, are not so different that the consumer can not make observations, gather experience, and adjust “buying” behavior. Where medical care is urgent, medical events infrequent, and care decisions highly complex or specialized, consumers have little real chance to perform as intelligent consumers. But in many situations, they do.

Contrast this with health insurance. First, for many working Americans, the choice of health insurer is as a practical matter severely truncated. The good news is that for workers who receive health insurance as a fringe benefit, they have health insurance that is “free” or at least heavily subsidized by the employer.³³ The bad news is that they are at the

33. But the cost of group health care is of course anything but free. *See Health Premiums Rise 6.1%; Average Family Coverage Costs \$12,000*, INS. J., Sept. 12, 2007, available at <http://www.insurancejournal.com/news/national/2007/09/12/83416.htm>. (discussing Employer Health Benefits Survey by Kaiser Family Foundation and Health Research and Educational Trust). *Accord*, Emily Fredrix, *Costs rise for health insurance*, L.V. REV. J., Sept. 12, 2007 at D1, col 4. *See also* Milt Freudenheim, *At a Small Business, One Illness Can Send Insurance Costs Soaring*, N.Y. TIMES, May 5, 2007, A1, col. 4. Jerry Geisel, *HMO rate hikes to decelerate again in 2007: Survey*, BUS. INS., Mar. 15, 2007, p. 25 (HMOs report “seeking rate increases averaging 11.7% for 2007;” despite the double-digit increase, it was “the forth consecutive year of declining rate increases, according to a consulting firm’s analysis.”). In addition, the amount employer-subsidized group insurance in force is shrinking. *See* Krugman, *supra* note 18, at 231 (declining from 62.1 percent in 1987 to 59.5 percent in 2005).

Most families, of course, do not realize that they are paying an average of \$12,000 per year in insurance premiums because much of the cost is borne by the employer of at least one of the adult family members. But they “pay,” of course in that the employer-funded portion of insurance is taken out of the employee’s paycheck prior to receipt by the employee, as is the employee’s portion of the premium payment. As market-oriented commentators are correct to point out, this has the effect of shielding the true cost of insurance from workers and consumers, with many thinking of it as a “free” perk that comes with the job. This in turn undoubtedly makes the worker/consumer less cognizant of price increases and less reactive than would be the case in a normal over-the-counter market transaction.

My point, however, is that even if the consumer was slapped in the face with these premium costs, the market for insurance would be a very imperfect one. First, as discussed in text, individual consumers are pretty ill-equipped to be intelligent and effective purchasers of medical insurance. Second, when actually feeling the pain of \$1,000 a month in premiums, many consumers will be reluctant to purchase the type of medical insurance they need and will often foolishly forgo insurance altogether both because of other pressing financial needs and because the “endowment effect” of having the money in their pockets will make it more painful for them to purchase the insurance with after-tax dollars than to suffer indirectly through the largely employer-funded group health system. In addition, there is the problem of individual consumer loss of buying power when converted to

mercy of whatever group health insurer(s) or plan(s) the employer has arranged.³⁴ At most, the typical employer will have arranged for one or two HMO options and one or two different preferred provider networks from which the consumer can choose.³⁵ If the employee is dissatisfied with the work-related group insurance options, he can in theory go to a different insurer, but it will cost him foregone benefits (the employer subsidy is wasted) as well as substantial out-of-pocket costs in addition to significant search costs spent selecting a competing insurer. As a practical matter, then, there is no effective choice of insurers for many workers, although they are the “lucky” ones in the United States because they at least have medical insurance.

Where the individual consumer is shopping for individual medical insurance, the problems are daunting. Many insurers will simply not be interested in serving this market at all. Those that are by definition are not doing as well as they would like selling more lucrative group insurance or stop-loss policies to self-insuring employers. The insurance products offered will be complex and difficult for the average consumer to understand or obtain information regarding the proposed policy and its applications.

Consider the matter of pre-existing conditions. By now, most educated Americans have at least heard about restrictions on coverage for pre-existing conditions. But they are unlikely to know how the restriction will be applied in practice. Even a trained lawyer reading judicial opinions on

purchasing individual insurance rather than participating through an employer-sponsored group plan.

34. See Charles Duhigg, *Aging, Frail and Fighting Insurers to Pay Up*, N.Y. TIMES, Mar. 26, 2007, A1, col. 3 (describing travails of insured attempting to obtain coverage (to which she pretty clearly seems entitled) from long-term care insurer); Robert Pear, *Loss of Competition Is Seen in Health Insurance Industry*, N.Y. TIMES, Sunday, April 30, 2006, 19, col. 4; *Report Finds Limited Competition In Nation's Health Insurance Market*, INS. J., April 21, 2006, available at www.insurancejournal.com/news/national/2006/04/21/67456.htm.

35. And if the employer-provided group health plan is not sufficient for the patient's needs, the patient or her family may face substantial uninsured medical bills. See John Carryrou, *As Medical Costs Soar, The Insured Face Huge Tab: Jim Dawson Hit Cap After Hospital Padding; The \$1.2 Million Bill*, WALL ST. J., Nov. 29, 2007 at A1, col. 4; Chad Terhune, *Covering the Uninsured, But Only up to \$25,000*, WALL ST. J., April 18, 2007, A1, col. 4 (describing limits of Tennessee program to provide private medical insurance to the uninsured); Milt Freudenheim, *The Check is Not in the Mail: Late Payment of Medical Claims Adds to the Cost of Health Care*, N.Y. TIMES, May 25, 2006 at C1, col. 2. See also *Benesowitz v. Metropolitan Life Ins. Co.*, 870 N.E.2d 1136 (N.Y. 2007) (enforcing medical insurance coverage limitation for pre-existing conditions; rejecting insured argument of violation of state regulation).

the subject would have difficulty giving a client ironclad advice about whether his or her prior medical problems make the exclusion or restriction applicable, much less whether the insurer will force the policyholder to litigate seeking coverage under various possible scenarios.³⁶

Contingency is of course at the heart of insurance. People buy medical insurance because of the contingent risk of developing health problems. Even with the risks of adverse selection and moral hazard (both which tend to be overstated in this context),³⁷ consumers are unlikely to have any real idea of whether they will be health “winners” (who have only a few significant adverse medical events in their lives) or health “losers” (who have more than their share of health problems or injuries). They are certainly unlikely to be able to predict the cost of these events and the outcomes. A buyer of health insurance may skate through life without more than annual check-ups or may become a regular prescription user subject to several expensive operations or chronic expensive treatment. Thus, right at the outset, a prospective purchaser of insurance is at a practical loss to know what type of coverage and what amount of coverage is needed.

The consumer thus depends on the insurer to put together and market an apt product for the contingencies facing the consumer. To the extent the product is standardized, comparison shopping, at least according to premiums charged, is facilitated. But where policies differ at the margin (and medical insurance is less standardized than life, auto, and general liability insurance), comparison again becomes difficult because the differences will be hard to detect and hard to decipher when detected. Unlike large businesses, individuals are far less likely to have the services of a knowledgeable broker, independent agent, or attorney who can note and explain the differences.

Most difficult, however, for comparison purposes is that the consumer will not readily be able to predict the insurer’s behavior in the event of a claim. Among insurance insiders, certain carriers are known to be more hospitable, even magnanimous, toward claims while other insurers have a reputation for fighting many claims on technicalities and even lapsing toward bad faith too often in an effort to maximize profits at the expense of the insurer’s fiduciary-like duty to its insureds. But most consumers lack any such information. Like lambs led to the slaughter, they may joyously

36. See, e.g., *Benesowitz v. Metropolitan Life Ins. Co.*, 870 N.E.2d 1136 (N.Y. 2007).

37. See Peter Siegleman, *Adverse Selection in Insurance Markets: An Exaggerated Threat*, 113 YALE L.J. 1223 (2004).

march into the arms of an insurer that offers a seemingly comprehensive product at relatively low cost only to find that if a claim arises (particularly a big claim), the insurer fights it with a ferocity typically found among revolutionary guerillas.

Even for sophisticated business consumers of insurance, it is hard to predict whether the insurer will be difficult or reasonable regarding claims. Individual claims adjusters may vary. The insurer may have personnel changes at the top that convert a formerly reasonable insurer to one that fights every claim tooth and nail. The insurer may decide to outsource its claims function to a third party administrator (TPA), managing general agent (MGA), or independent adjuster. The chosen entity may be competent and reasonable or may be incompetent and excessively stingy, owing to either its low cost and lack of training/expertise³⁸ or to a philosophy holding that a tough claims stance will increase insurer profit and future use of the claims entity. The situation may get better or worse depending on intervening judicial decisions. A jurisdiction that put constraints on insurer self-dealing at the beginning of a policy period may issue a new opinion giving insurers more discretion that may in turn result in more obstreperous claims stances.

Most important, the insurance contract is aleatory, no matter how sophisticated the consumer or business purchasing insurance. An aleatory contract is one in which the exchange is, unlike most contracts, not equal. The insurance policy could be anything from a great deal to an abysmal bargain for the participants.³⁹ For example, if the insurer has no claims

38. *See, e.g.*, *Gallagher Bassett Services, Inc. v. Jeffcoat*, 887 So.2d 777, 779-80 (Miss. 2004) (describing independent adjuster retained by insurer and its performance, which included assigning an individual adjuster to the case who was not licensed in the relevant state, had no training in matters pertinent to the claim, was unaware of relevant state law regarding “stacking” of insurance benefits until advised by claimant’s counsel, failed to obtain necessary legal opinion, misrepresented her efforts to claimant, and failed to obtain relevant coverage documentation necessary to make determination of claim; Incredibly, court deems this litany of failing mere negligence as a matter of law and insufficient evidence of gross negligence necessary to maintain claim against adjuster, overturning jury verdict finding gross negligence).

39. Regarding insurance policies as aleatory contracts, see JEFFREY W. STEMPEL, *STEMPEL ON INSURANCE. CONTRACTS* § 1.06 (3d ed. 2006 & Supp. 2008); EMERIC FISCHER, PETER NASH SWISHER & JEFFREY W. STEMPEL, *PRINCIPALS OF INSURANCE LAW* § 2.02 (Rev. 3d ed. 2006 & Supp. 2006); GEORGE E. REJDA, *PRINCIPLES OF RISK MANAGEMENT AND INSURANCE* 99 (9th ed. 2005) (“An aleatory contract is a contract where the values exchanged may not be equal but depend on an uncertain event. Depending on chance, one party may receive a value out of proportion to the value that is given.”) (emphasis removed); MARK DORFMAN, *INTRODUCTION TO RISK MANAGEMENT AND INSURANCE* 163 (8th ed. 2005)

during a policy period, the premium received is almost pure profit that earns investment income forever more. Alternatively, the insured may be severely injured the day after becoming subject to coverage. Even if the insurer behaves dishonorably in response to this type of claim, it will almost certainly pay far more in benefits and disputing costs than it ever received in premiums from the particular claimant in question.⁴⁰ Conversely, the policyholder may in some cases receive coverage far in excess of premiums paid or in other cases pay premiums for decades and receive nothing in return. (This is not impossible even though everyone gets sick once in awhile. The insured may never be sick enough, often enough to exceed the deductible amount of the policy, which is shouldered by the insured).

In short, one does not know who wins or loses regarding an insurance purchase until years or even decades later. Contrast this to most other consumer purchases. Even where the good or service bought is complex or expensive (e.g., a car, a home), the exchange is thought to be equal, because the parties are able to make a real time comparative evaluation of value. A resident of Omaha, Nebraska may think the consumer is nuts to have paid \$500,000 for a two-bedroom house in Silicon Valley, but this is the price the market has set and it may make sense in light of the consumer's objectives (e.g., a short commute to Google headquarters in which he not only works but effectively lives for twenty hours each day),

("The aleatory feature of insurance policies differs from other [commutative] business contracts where consideration of equal value is exchanged.") (emphasis removed).

40. But applied to its book of business as a whole, insurers may find that acting dishonorably is profitable. Although they may ultimately pay far more in benefits than was received in premiums for a particular policyholder, the insurer's war-of-attrition may succeed in getting insureds to drop meritorious claims or settle them at pennies on the dollar.

Unless the claim is sufficiently large, the insured will have trouble finding an attorney willing to take the case on a contingent fee basis (unless the insurer's position is so clearly unreasonable that it makes a bad faith suit with punitive damages likely, but caps on such damages may make a small dollar case of even egregious insurer misconduct unattractive to plaintiffs' lawyers). For most people, this means they cannot obtain legal representation because their budgets preclude them from paying counsel's normal hourly rate. In addition, the insurer's "tough" stance on claims may become sufficiently known to further discourage lawyers from becoming involved and to prompt early, "lowball" settlements with policyholders.

Perhaps most important, an insurer-wide policy of stringing out claims payments as long as possible permits the insurer to reclaim through investment income whatever underwriting loss it may have suffered in connection with individual instances of insureds who incur covered medical costs in excess of the amount of premiums paid to insurers.

which are not contingent in the manner of fortuitous health problems or other loss events. As a general rule of economics, we do not look past the observed purchasing preferences of consumers. If a thirteen-year-old thinks that a Hannah Montana album is worth \$14.99, that's its value, no matter how much one's own taste may run in a different musical direction. The parties can value the exchange as they see fit even if third parties may question their taste or valuation.

But insurance is different – particularly for the consumer – because it is an economic transaction centered on risk and contingency. Insurers and more sophisticated business entities can mitigate the uncertainty of the aleatory contract by making actuarial calculations based on experience, comparable population data, or longitudinal studies. Most important, they pool contingent risks and through the law of large numbers can make reasonably well-calculated estimates regarding future medical care needs. By contrast, consumers will either lack access to such information or as practical matter be unable to expend the money and time necessary for such evaluations. The typical individual is simply not in a position to be a very intelligent consumer of insurance, particularly health insurance.

Currently, the private sector provides some counterweight to this imbalance of expertise through the dominance of employer-provided group medical insurance. In contrast to the individual insured, the employer has the resources, experience, and leverage to make better estimates and strike better bargains with private insurers. But this field-leveling power of the employer remains less powerful than the accumulated expertise and resources of the insurance industry.

More important, employers may not have the motivation to fully deploy their resources on behalf of insured workers. Despite its responsibilities as a benefits provider, the employer's zeal will be diluted by a desire to keep costs down. It will be tempted to spend less for inferior coverage from a difficult insurer so long as not hard-pressed by the workforce. Individual workers are unlikely to apply such pressure. Unions are more likely to be effective advocates for employee group insureds, but unions have declined in membership to the point where only about 15 percent of the workforce is organized. Employer-provided insurance as a whole has declined in recent years as well.⁴¹

For many employers, minimalist group insurance is their optimal economic strategy. Prospective workers are looking primarily for a job rather than medical coverage (which is why the danger of adverse selection

41. See Jost, *Health Insurance a Bad Idea?*, *supra* note 4.

is overstated) and, as discussed above, have only limited expertise about medical insurance. Consequently, workers and job applicants will not exert particularly powerful leverage forcing employers to achieve optimal medical coverage for their workforces. We cannot be completely confident that employers will be faithful agents of employees concerning the purchase of medical insurance.

B. THE LEGAL FICTION OF INDIVIDUAL CONTROL OF HEALTH

The second legal fiction, which also becomes part of the legal friction between individualism and collective solidarity, is the increasing tendency to implicitly assign fault to persons experiencing adverse health events and medical costs. More important, the typical consumer will not have much if any effective control over his or her medical care needs and costs. But because of the John Wayne mythology of rugged individualism and personal responsibility, society (and analysts and policymakers who should know better) act as if the individual has some meaningful control over his or her health. For example, people frequently refer to someone “beating” cancer or “battling” illness, as though one’s failure to stay healthy or recover were solely a function of one’s efforts and abilities.⁴² In reality, good or bad health, more than economic success or emotional happiness,

42. See SUSAN SONTAG, *ILLNESS AS METAPHOR* (1978) (describing her struggles with breast cancer and noting social tendency to see illness and treatment as analogous to protagonist in conflict with adverse entity rather than fortuitous circumstances controlled by genetics or inexorable environmental factors). See also DAVID RIEFF, *SWIMMING IN A SEA OF DEATH* (2008) (Sontag’s son chronicles her myriad medical problems and attempts to overcome them).

One particular example of this tendency in popular culture sticks in my mind. During the 1970s and 1980s, sportscasters often referred to Jack Pardee, a former Los Angeles Rams coach and one-time star player (a linebacker for the Rams and the Washington Redskins) as “beating” black mole cancer, expressing some awe due to the rareness of recovery from the disease at that time.

This, of course, is an empirically ridiculous way of putting it. Pardee was a great player and a tough guy. But he did not vanquish his cancer. He recovered from it through good medical care and luck. His recovery was not a testament to any moral, mental or physical superiority just as it would not indicate deficiency in these areas had he died from the cancer. Depending on chance circumstances, the same type of virus might kill Arnold Schwarzenegger but leave Pee Wee Herman relatively unscathed. Strength, athletic ability, intelligence, and determination have little or nothing to do with whether one gets sick or recovers. But we continue to talk about illness in these misleading terms.

results far more from chance than from personal decisionmaking, conduct, discipline or effort.⁴³

For years, insurers have waged a semantic and psychological campaign against the notion of blameless fortuity in adverse events and at least suggested that many losses are not true accidents of chance but are to a significant degree the fault of insureds. For example, automobile mishaps are no longer labeled “accidents” by most insurance personnel. Instead, they are trained to speak of “collisions” and “crashes” that imply fault on at least someone’s part (usually the driver covered by another insurer).⁴⁴ In health insurance, this more generally takes the form of the suggestion that while the insured does not knowingly become ill, the insured’s lifestyle and negligence may have created or contributed to the health problem that now requires medical care.⁴⁵ This view, although possessed of some merit in the aggregate, is generally not a productive way to think about individual medical needs and insurance claims.

In a large enough group of persons, their lifestyles will at least in some cases ultimately show significant impact on adverse health events and consequent medical care. For example, a group of chain smokers will eventually have much higher rates of heart disease, lung cancer, emphysema, and related maladies associated with smoking while a similar group of nonsmokers will, absent other factors, have fewer such adverse health events and lower medical care costs.

In the aggregate, it therefore makes considerable sense to promote the reduction of medical risk through encouraging better lifestyles among insurers. Programs to promote exercise, healthy eating, nonsmoking, moderation in alcohol use, and avoidance of illegal drugs or unregulated

43. See Jacobi, *supra* note 4, at 562 (noting that ten percent of population “accounts for almost 70 percent of the health care costs, and the top 2 percent accounts for almost 40 percent of the costs.”).

44. See RICHARD V. ERICSON, AARON DOYLE & DEAN BARRY, *INSURANCE AS GOVERNANCE* Ch. 3 (2003). For one example of the tremendous public relations resources deployed by the insurance industry, see Peter J. Howe, *Firm He Hired to Buff Image is Suing Mogul; Cambridge PR Shop Says it’s Owed \$2M*, BOSTON GLOBE, Mar. 10, 2007 (public relations firm eSapience Ltd alleges former AIG CEO and insurance executive Maurice “Hank” Greenberg owes \$2 million for services purchased when he sought to burnish his image tarnished by then-New York Attorney General and later Governor Eliot Spitzer’s investigation of AIG; bills ranged as high as \$978,000 for a month’s assistance in presenting Greenberg in “best light and to assure the presence and participation of key intellectual and public figures” at events involving Greenberg, according to complaint).

45. See Mariner, *Social Solidarity and Personal Responsibility in Health Reform*, *supra* note 22.

supplements all help group members as a whole, society, the medical profession, and reduce medical care usage and costs.

Paradoxically, however, the current system of crazy-quilt private patchwork insurance does little to foster these efforts. Most insurers fail to cover many potential efforts to enhance prevention of illness through better lifestyle. Historically, private insurers have been slow to cover preventive medical care such as annual checkups. This appears to result from a combination of short-sightedness, concern about overuse of this type of benefit, and the more calculatingly disturbing but perhaps correct business decision that paying for prevention in the instant policy period simply lowers some future insurer's cost of covered care in subsequent policy periods.⁴⁶

But whatever the merits of preventive care and a health lifestyle, I find it disturbing that so much of modern health care and insurance rhetoric seems to uncritically accept the notion that much of medical need results from the insured patient's own failings of discipline rather than the simply fortuity of genetics and luck. Although a group as a whole will reflect the benefits of healthy lifestyle, individuals within the group may or may not enjoy the benefit. For example, a non-smoker who wins marathons and has low blood pressure and cholesterol may nonetheless drop dead from a sudden heart attack. Or he may be stricken with cancer. Or rear-ended by a truck. Or infected while making a blood donation.

Conversely, the 300-pounder who stands 5'8" tall and smokes two packs a day may live to be 100. When observers conclude that because each individual within a group demonstrates the whole group's characteristics, they make what statisticians term the "ecological" fallacy.⁴⁷ For example, it would be erroneous to conclude that every union member

46. This is why also why Hyman is overly optimistic in positing medical insurers will engage in an optimal level of preventive care in the absence of government regulation. See Hyman, *Health Insurance: Market Failure or Government Failure?*, *supra* note 4. In addition, as Mariner notes, preventive care and wellness programs raise the prospect of deviating from the fortuity model of insurance and creating a situation that (like HSAs, HRAs and other consumer-driven proposals) tends to benefit the upper socioeconomic strata much more than their lower SES counterparts. See Mariner, *Social Solidarity and Personal Responsibility in Health Reform*, *supra* note 22.

47. See Jerry Mashaw, *The Economics and Politics the Understanding of Public Law*, 65 CHI.-KENT L. REV. 123, 150 (1989) ("Behavior found to characterize a population, at the population level, has been fallaciously assumed to characterize the behavior of individuals in the population"); Gerald Kramer, *The Ecological Fallacy Revisited: Aggregate-versus-Individual Findings on Economics, Elections, and Sociopolitical Voting*, 77 AM. POL. SCI. REV. 92 (1983).

voting in a Democratic primary supported John Edwards, although it is true that he enjoyed (at least during the early stages of the 2008 campaign) considerable support from that group as a whole. Non-statisticians intrinsically realize that this is incorrect but are often overly casual in stereotyping based on subconscious application of the fallacy (e.g., looking at a plumber with a lunch pail on his way to the polls and assuming he is a vote for Edwards).

Much of the rhetoric about consumer/patient responsibility in health care comes dangerously close to embracing the ecological fallacy. It suggests, at least implicitly, that people with health problems are at least partially responsible and that it is therefore unfair or unwise to pool them with people who are comparatively free of health problems or the need for expensive medical treatment. This attitude is simply not rational as applied to the serendipitous nature of health problems and the need for medical care.

Only in extreme cases (e.g., the self-destructive risk-taker, the spendthrift hypochondriac), can it legitimately be said that individual patients had a significant role in maladies that have afflicted them or the total amount and cost of treatment. Much of adverse health and medical experience results from simple bad luck. It is wrong to suggest, even indirectly, that this results from the patient's failures and that the patient is therefore less deserving of adequate medical care and insurance coverage than those blessed with better medical fortune.⁴⁸

But the rhetoric in much of the health care and insurance debate, even if not strictly inaccurate, is slanted in favor of overstating the individual's control over her health history and the relative desert of certain individuals. For example, use of a term such as "personal responsibility" is simply overdone and misleading for many health issues.⁴⁹ A person stricken by

48. See Deborah Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity*, 6 CONN. INS. L.J. 11, 12 (1999).

49. But this terminology is so hard-wired into our discussions of medical issues that it pervades even scholarly treatments that do not embrace an unrealistic view of an individual's ability to control his own health care options. See, e.g., Mariner, *Social Solidarity*, *supra* note 22; Lois Shepherd, *Assuming Responsibility*, 41 WAKE FOREST L. REV. 445 (2005); Carol A. Heimer, *Responsibility in Health Care: Spanning the Boundary Between Law and Medicine*, 41 WAKE FOREST L. REV. 465 (2005); Lois Shepherd, *Face To Face: A Call for Radical Responsibility in Place of Compassion*, 77 ST. JOHN'S L. REV. 445 (2003). Reading the titles of these articles alone, one might first erroneously assume that they are part of the John Wayne ethos when they are in fact written from a communitarian social justice (Mariner, Shepherd) or professionalism (Heimer) perspective. The rhetoric of market, rugged individualism, and aversion to government programs is so strong in the U.S.

cancer clearly is not at fault. A person injured in an auto accident or workplace mishap may have been negligent but this hardly amounts to personally irresponsibility. As the insurance industry well knows, everybody is negligent at times but not every instance of negligence results in damage to self or others. Although behavior may contribute to problems with diabetes, heart or lung disease, much of medical outcome is a metaphorical roll of the hereditary and biological dice. Personal responsibility rhetoric implicitly blames people more accurately described as victims and provides a subconscious salve permitting society to overlook the problem of an inadequate national approach to medical coverage.

A term like “actuarial fairness,”⁵⁰ although it may be technically accurate and useful in describing risk populations, is also rhetorically overloaded with the connotation that sick people have largely been their own worst enemies (or at least must lump their conditions). Implicitly, providing coverage to those making higher demands on the medical system is “unfair” to those at lower risk or presenting fewer current demands. This nomenclature makes it easier to avoid a sufficiently comprehensive solution because it implicitly suggests that any government efforts extending beyond a market-based solution is unfair to the bulk of society and unfairly subsidizes the medical needs of the undeserving.

The net effect of this type of discourse is to reinforce the traditional American notions of rugged individualism and the optimal efficiency of markets, creating a climate where policymakers can implicitly take the position that doing more for those who are sicker, poorer, or less skilled in navigating the world carries too high a price tag, both economically (e.g., higher taxes, higher premiums, higher medical costs) and socially (e.g., enhancement of the “nanny state” in derogation of the preferred ethos of rugged individualism).

In addition to being an unfair attack on the ill and the risky, the rhetoric of individualism and market veneration is amazingly unempathetic. John Wayne was able to achieve his goals in large part because he was never seriously injured or ill, at least not prior to accomplishing his mission.⁵¹

that the immediate connotative reaction (mine, at least) to the term “personal responsibility” is to assume the speaker is advocating a “let the chips fall” position in which the individual stands alone, protected only by contract and individual fortitude.

50. See Mariner, *Social Solidarity*, *supra* note 22 (using term throughout and also using term “personal responsibility” throughout).

51. In the 1969 movie *TRUE GRIT*, for which he won an Oscar, Wayne was wounded while dispatching the villain but the seriousness of the wound, which ultimately did him in, did not manifest itself until after the shooting was over. *TRUE GRIT* (Paramount Pictures

Today, some health insurance commentators would seemingly be unwilling to chalk up adverse health events to fortuitous chance and would instead wonder whether they had instead not brought this upon themselves through lifestyle factors (e.g., smoking, poor diet, insufficient sleep, poor hygiene).⁵² This implicit appeal to the John Wayne iconography of America is used as a selling point for certain insurance and financial products by appealing to the public through rhetoric about “consumer choice” or “freedom” or an “ownership society” when these initiatives will, for most people, be far less helpful than a government-administered single payer system.⁵³

1969). Of course, defenders of rugged individualism might suggest this simply demonstrated will power (such as in the famous Jesse Ventura line (in the movie *COMMANDO*, which also starred a similarly macho-iconographic Arnold Schwarzenegger) “I ain’t got time to bleed” until the mission is completed). *COMMANDO* (SLM Production Group 1985). While the laws of biology and physics (e.g., blood escapes rapidly when one is shot in a vital organ) may be suspended in Hollywood, they very much limit the ability of ill persons to surmount their maladies through exercises of personal responsibility.

52. See, e.g., NATIONAL GOVERNORS ASSOCIATION, *MEDICAID REFORM A PRELIMINARY REPORT FROM THE NATIONAL GOVERNORS ASSOCIATION* (2005), <http://www.nga.org/cda/files/0506medicaid.pdf> (positing need for “incentives and penalties for individuals to take more responsibility for their health care”); Craig Thomas, *Understanding Rural Health Care Needs and Challenges: Why Access Matters to Rural Americans*, 43 HARV. J. ON LEGIS. 253, 255 (2006) (in addressing needed actions on health care, U.S. Senator Thomas argues that “most importantly, individuals must take personal responsibility for their health”); Richard L. Kaplan, *Who’s Afraid of Personal Responsibility? Health Savings Accounts and the Future of American Health Care*, 36 MCGEORGE L. REV. 535 (2005). But see Shepherd, *Assuming Responsibility*, *supra* note 49 (taking different perspective and placing responsibility on society to provide medical care and alleviate suffering for the ill); Heimer, *supra* note 49 (focusing primarily on responsibility of medical professionals to patients and society).

53. See Deborah Stone, *Health Law Symposium: The False Promise of Consumer Choice*, 51 ST. LOUIS U. L.J. 475, 475 (2007) (“In these times, the new buzzwords for market reform are ‘consumer choice,’ ‘consumer direction,’ ‘consumer empowerment,’ and ‘ownership.’ [T]he rhetorical emphasis on power and control for consumers disguises the real impact of market reforms, which is primarily to reduce the collective assistance and medical services that citizens receive.”). See also Monahan, *Ownership Society*, *supra* note 17 (finding useful incentive structures in consumer-driven plans but also that consumers are not particularly adept purchasers of health care).

The Legal Fiction of the Reliable Responsibility of Individuals (and the Contradictory Legal Fiction that Individuals Are Louts Who Need Stern Market and Insurer Discipline)

In addition to the rhetoric about personal responsibility concerning illness itself, there is also the suggestion in much of the debate that persons lacking adequate insurance when illness strikes are in this pickle largely through their own failure to pay the required social toll of insurance. For example, we are frequently reminded that many who do not receive medical insurance through a job will go without insurance rather than pay premiums for an individual policy. Some may even describe this as a rational decision but one that adversely affects the nation's ability to provide medical insurance that is properly funded by those who will benefit from it. For example, younger persons who are less statistically likely to have medical problems often fail to purchase insurance. As a result, the private insurance system is deprived of their premium dollars and the insurance system as a whole is underfunded. But when a twenty-eight-year-old ruptures an appendix, he will generally be able to obtain treatment at an emergency room.

The picture painted, with considerable justification, is that people like this are freeloading on the system. In reaction, even those favoring continued substantial reliance on private medical insurance urge that such persons be required to purchase insurance and heavily penalized if they do not. This is a major underpinning of the well-publicized Massachusetts plan and the health care proposals of Hillary Clinton and John Edwards.⁵⁴

This is not the place to discuss mandates at length but it should be noted that mandates tend to be far less effectual than commonly supposed.⁵⁵ Consider auto insurance, where for decades every state has

54. For a summary of the Massachusetts plan, see Elizabeth A. Weeks, *Failure to Connect: The Massachusetts Plan for Individual Health Insurance*, 55 KAN. L. REV. 1283 (2007).

55. See Hyman, *Good, Bad & Ugly*, *supra* note 14, at 1111 (expressing skepticism about efficacy of insurance purchase mandates); Gilles, *The Judgment-Proof Society*, 63 WASH. & LEE L. REV. 603, 705 (2006) (noting difficulties with and practical limitations on suggested liability insurance purchase mandates); Logue, *The Current Life Insurance Crisis: How The Law Should Respond*, 32 CUMB. L. REV. 1, 45 (2002) (mandates create collateral problems such as affordability for the poor and lower middle-class); John Jacobi, *The Ends of Health Insurance*, 30 U.C. DAVIS L. REV. 311, 388 (1997) (describing mandated purchase of health insurance as "politically problematic"); David A. Hyman, *Professional Responsibility, Legal Malpractice, and the Eternal Triangle: Will Lawyers or Insurers Call the Shots?*, 4 CONN. INS. L.J. 353, 370 (1997) (noting lack of success of movement to

had financial responsibility laws that require, as a condition for licensing a motor vehicle, that the owner purchase and maintain auto insurance. The required minimum amounts of such insurance are shockingly low in many states and the premiums, although non-trivial, are hardly astronomical, at least for the low policy limits minimally required. However, experience shows that a large portion of the driving public fails to maintain the required insurance.⁵⁶

There is little reason to think that medical insurance mandates will be significantly more effective. The reason: many people, especially at the economic margin, will shirk legal obligations that cost money if they can do so without significant penalty. In response, proponents of mandated purchase of private insurance seek to use penalties to create sufficient incentive for citizens to purchase required insurance. Although like auto insurance financial responsibility laws, this will work to a degree and improve upon an unfettered free market atmosphere, there is no reason to think that it will work better overall than auto insurance.

Most likely, it will work less well. At least for a few hours on a given Tuesday, anyone wanting a license plate will need to have at least some auto insurance in force. By contrast, there is no similar mandatory event, at least not one occurring prior to when insurance is needed, which will apply to all potential policyholders. The twenty-something Starbucks worker and the impoverished family of four can more easily bypass insurance mandates than can their driving counterparts. Absent a police state-like increase in law enforcement infrastructure, they will be seriously scrutinized and “caught” in their failure to procure insurance only after they have suffered an adverse medical event.⁵⁷

mandate malpractice insurance for lawyers); James E. Holloway, *ERISA, Preemption and Comprehensive Federal Health Care, A Call for “Cooperative Federalism” to Preserve the States’ Role in Formulating Health Care Policy*, 16 CAMPBELL L. REV. 405, 422 (1994) (noting that mandates alone do not “provide benefits for the unemployed, indigent, and uninsurable”); Katherine Pratt, *Funding Health Care with an Employer Mandate: Efficiency and Equity Concerns*, 39 ST. LOUIS L.J. 155 (1994). But see Tom Baker, *Containing the Promise of Insurance: Adverse Selection and Risk Classification*, 9 CONN. INS. L.J. 371, 380 (2002) (finding potential significant utility in health insurance purchase mandates).

56. See Rebecca Cathcart, *California Taking Aim At Uninsured On the Roads*, N. Y. TIMES, Dec. 3, 2007, at A22 (Twenty-five percent of California drivers uninsured despite longstanding requirement of insurance purchase as prerequisite for licensing car).

57. See Jost, *Bad Idea?*, *supra* note 4 (noting studies showing reduced use of medical services by uninsured and failure of younger, healthier demographic groups to purchase medical insurance).

But we continue to think of mandated private insurance as comprehensive solution to the health insurance problem, just as we have viewed mandated auto insurance as an effective public policy tool. This is unwise. A sufficiently high number of persons will fail to purchase medical insurance and pay premiums into the system for funding expanded health care. Whether this occurs because they are irresponsible shirkers and slackers or because they are simply too poor, unsophisticated, or unorganized to make the required purchase is beside the point – or at least beside my point.

My point is that even the “progressives” or “reformers” in the area of medical insurance, driven by perceived political pragmatism if not thorough analysis, have erroneously viewed private insurance purchase mandates as a near-panacea in large part out of misplaced continued belief in the legal fiction of the effectiveness of individual personal responsibility. At a minimum, this legal fiction posits that if required to purchase insurance, individuals will do so promptly and responsibly in most all cases. But if this estimate is correct, people would also purchase medical insurance even in the absence of mandates and would place such purchases ahead of other desired goods and services. Historical and empirical evidence is quite to the contrary. Instead, people either consciously or negligently fail to obtain insurance, even when they could at least in theory afford it. A more realistic view of human behavior would embrace the more enforced community solidarity of a government administered single payer plan.⁵⁸

In addition, the legal fiction of individual rationality and omniscience also posits that when purchasing insurance, consumers will do so wisely and efficiently. But, as discussed above, most laypersons lack the

58. See Stone, *False Promise*, *supra* note 53, at 478:

[W]hen people live at the margin, they are apt to choose the option with the lowest short-term costs over the one with the lowest long-term or total costs. People living at the margin—and that margin may be well up into the middle class when families face chronic disease, disability, job loss, income decline, and all the other factors that make for economic squeeze – are simply not able to behave like the rational economic actors of consumer choice theory. They cannot afford to take the long-term view. They are forced to be “penny wise and pound foolish.”

See also *id.* at 480 (“perhaps the worst feature of the consumer choice approach” is that “it substitutes lay judgment for professional judgment.”).

knowledge, experience, training, or sophistication to understand and differentiate insurance products and providers. In contrast to the prevailing legal fiction, they are not good consumers of medical insurance. Even when people dutifully follow mandates to buy medical insurance, they will frequently make suboptimal choices regarding necessary coverage and make errors in choosing among whatever options are presented to them by the private market.⁵⁹ Consequently, a system premised on the wisdom and utility of consumer choice via John Wayne-style individualism and invisible hand market behavior is unlikely to achieve sufficiently comprehensive and adequate medical insurance or medical care for the population at large.

C. THE LEGAL FRICTION OF MARKET MYTHOLOGY AND RUGGED
INDIVIDUALISM IN TENSION WITH BOTH ITSELF AND IN
TENSION WITH SOCIAL JUSTICE AND COMMUNITY
SOLIDARITY

As discussed above, the American ethos has been to erroneously assume too much understanding and discipline by the consumer of insurance and to view with disdain the consumer who fails to make good insurance choices. At the same time, empathy is not completely dead in American society. We worship idealized concepts of rugged individualism and personal responsibility but are unwilling to adopt a completely Darwinian approach to the ill or injured. Although there is a substantial amount of “blaming the victim,” for health problems, Americans do not completely turn a cold shoulder to the ill or injured. The iconic image of Martin Luther King and the attendant social justice notion still competes for the hearts and minds of the public on issues of health care. Similarly, although the market efficiency wing of Adam Smith’s own writings dominates much of the discourse, his thoughts on the importance of a

59. The Massachusetts plan and similar initiatives attempt to deal with this problem by placing some requirements on insurers as to the minimum content and features of health insurance policies sold. Like mandated private coverage itself, this regulatory effort is better than nothing, but it will leave many consumers without optimal coverage for their needs. However, to the extent that government-required minimum features of a medical insurance policy are effective, this is actually a powerful argument for simply traveling the extra mile to a government administered single payer system. Logically, if regulators can design an effective basic medical insurance policy, they can also effectively design the contours of a fair single payer system. *See generally* Edward A. Zelinsky, *The New Massachusetts Health Law: Preemption and Experimentation*, 49 WM. & MARY L. REV. 229 (2007).

strong, competent, self-regulating professional class also play a role in the health care debate.

As the politicians continue to remind us during the 2008 election season, Americans are a compassionate people as well as a group that worships at the shrines of rugged individualism, personal responsibility and ambition. As a consequence, despite some rhetorical and social looking askance at the obese, the slothful, smokers, drunkards, and druggies, society (even its insurance element) has been unwilling to completely exclude most such people from coverage they would otherwise receive as members of an insured risk pool.

The inability of the body politic to adopt either the cold-hearted approach of letting the health or poor consumer choice chips fall where they may or the more emphatic communitarian approach of comprehensive universal health care leads to the legal friction or tension between allegiance to the norms of rugged individualism and personal responsibility and the recognition that, at least in the arena of human health, outcomes are often not within the control of the individual.

The result is, much like American medical insurance itself, a patchwork of occasionally spotty coverage that for the most part provides coverage even for the Louie Andersons (overweight) and Humphrey Bogarts (smoker) of the world but does so in a manner that may impose additional costs or reduced coverage, particularly when that person is not part of a group insurance plan. Increasingly, insurers in general have tried to restrict coverage accorded to insureds engaged in arguably wrongful or irresponsible activity and have tried to avoid providing medical insurance in such cases unless they can extract a sufficiently high premium. For auto insurers, we see this new judgmentalism in the form of clauses that exclude coverage if a car accident arises out of the policyholder's intoxicated driving or criminal act. For health insurers, we see measures such as broader and longer bans on coverage for pre-existing conditions, differential premiums rates based on lifestyle factors.

More important for purposes of the health care/medical insurance debate, the purported fault of patients provides insurers with an argument against single payer administration of universal coverage even if the argument is largely made sub silentio. Because of public ambivalence about how far to take the personal responsibility track in derogation of compassion, this argument has not been completely successful alone but at the margin has helped the status quo resist efforts toward universal health insurance coverage.

But this tension, like most, has strong elements of inconsistency, as does the so-called consumer driven health care movement. On one hand,

the theology of market-and-individual driven health care posits that many people are just too darned undisciplined, lazy and self-destructive and that, as a result, the costs that they bring upon themselves should not be heavily subsidized nor should the health consequences of their foibles be borne by a unified national insurance system. The consumer-driven, market-based model of medical insurance implicitly belittles individuals as undisciplined louts who fail to take adequate care of themselves, over-consume expensive medical care, and fail to exhibit apt discipline in lifestyle, insurance purchase, or resort to health care.

But on the proverbial other hand, the consumer-driven movement argues that individuals are sufficiently all-knowing that they don't need universal health care and single payer medical coverage and that they can make shrewd, disciplined insurance purchasing decisions. In addition, the movement posits that people will be similarly shrewd, disciplined, price-controlling consumers of medical services.

The inconsistency is palpable. The problem, of course, is that slothful slackers and the shrewd consumers are the same people, or at least comprise the same population pool. Some subgroup of the populace may meet the implicit John Wayne/Adam Smith assumptions underlying the consumer-driven health movement (just as every neighborhood has a few nerds who never unwittingly violate even the most arcane neighborhood association rules regarding aesthetics). But this subgroup is logically much smaller than posited by the movement – and too small to sustain movement health care. People are not completely incompetent in health matters, but comparatively few have the education, training, time, discipline, and energy to manage their medical insurance portfolio in the manner posited by those favoring continued or increased market control over medical coverage.

II. THE MYTHOLOGY OF THE MARKET AND OF PRIVATE INSURER EFFICIENCY

A seemingly stronger arrow in the quiver of the status quo is public concern that anything but a market-based, private sector model for medical insurance will be too inefficient and expensive. The Adam Smith legacy of a belief in omniscient and omnipotent markets has created an unhelpful mythology positing that private sector health care and insurance is so dramatically and consistently more efficient than any government-run or

hybridized model that it should be tinkered with only under the most dire of circumstances and only to the most limited degree.⁶⁰

At the risk of picking more of a fight than I have already begun, much of David Hyman's scholarship is in this vein, although he is also highly critical of the role of private insurer payers in the current patchwork system as well as critical of government single payer plans such as Medicare.⁶¹ It's clever, knowledgeable, insightful and well-written, with occasionally counterintuitive nuggets of some support for particular types of regulation or government efforts on behalf of patient rights.⁶² But regardless of whether one finds it persuasive, it seems undeniable that it all proceeds from a Smithian world view exceedingly enamored of markets and consumer choice.⁶³ (The Smith who advocated for professionals' financial

60. See Anna Bernasek, *Health Care Problem? Check the American Psyche*, N.Y. TIMES, Dec. 31, 2006, at B3 (noting resistance to government public insurance system based on American norms).

61. See e.g. Hyman & Silver, *The Poor State of Health Care Quality in the U.S.*, *supra* note 16, at 959 (2005) ("markets dominated by third-party payment arrangements function relatively poorly...[p]layers bear most of the costs of health care; patients enjoy most of the gains. Payers therefore care about cost more than quality."); David A. Hyman, *Regulating Managed Care: What's Wrong With a Patient Bill of Rights*, 73 S. CAL. L. REV. 221 (2001); David A. Hyman, *Health Care Fraud and Abuse: Market Change, Social Norms, and the Trust "Reposed in the Workmen"*, 30 J. LEGAL STUD. 531 (2001); David A. Hyman & Charles Silver, *Just What the Patient Ordered: The Case for Result-Based Compensation Arrangements*, 29 J. L. MED. & ETHICS 170 (2001); David A. Hyman, *Drive-Through Deliveries: Is "Consumer Protection" Just What the Doctor Ordered?*, 78 N. C. L. REV. 5 (1999); David A. Hyman, *Patient Dumping and EMTALA: Past Imperfect/Future Shock*, 8 HEALTH MATRIX 29 (1998); David A. Hyman, *The Conundrum of Charitability: Reassessing Tax Exemption for Hospitals*, 16 AM. J.L. & MED. 327, 370 (1990) ("In a world where patients are relatively ignorant about their medical conditions, a for-profit provider has a clear incentive to cheat on quality and quantity. Because there are no equity shareholders, nonprofit hospitals may be safer for the relatively helpless patient."). See also David A. Hyman, *Medicine in the New Millennium: A Self-Help Guide for the Perplexed*, 26 AM. J.L. & MED. 143, 152 (2000) (on the subject of "picking a fight": relating that his scholarship was described at one conference as reflecting "the sort of views that caused the Irish potato famine."). Presumably, I have not gone this far in my differing.

62. See, e.g., Hyman & Silver, *The Poor State of Health Care Quality in the U.S.*, *supra* note 61; David A. Hyman, *Does Medicare Care About Quality?*, 46 PERSP. IN BIOLOGY. & MED. 55, 65 (2003) (finding that Medicare does care about quality – but suggesting that it achieves it less well than would private insurer or uninsured markets).

63. For the best example of all these traits of Hyman scholarship, see DAVID A. HYMAN, *MEDICARE MEETS MEPHISTOPHELES* (2006) (discussing fictitious memorandum in the manner of C.S. Lewis' *The Screwtape Letters* (1942) revealing Medicare to be diabolic plot designed to drain Americans of virtues of thrift and truthfulness and lead them into seven deadly sins of avarice, gluttony, envy, sloth, lust anger and vanity); David A. Hyman,

success is largely missing in Hyman's work but, like Smith, he holds professionals to an implicitly high standard of care and competence). Hyman is hardly alone, at least outside the academy, where the seemingly dominant view among policymakers is that any comprehensive program to effect full medical coverage must involve private insurers and that there should be no program that effectively eliminates private insurers in favor of government.⁶⁴

Notwithstanding its political dominance, the dominant market paradigm for configuring medical coverage appears substantially incorrect on a number of grounds. First, despite the supposed marvels of the market in controlling costs, both health care costs and insurance premium rates are high and tending higher. Market defenders typically ascribe this to the effects of government subsidization of group medical insurance, which is generally a fringe benefit that workers receive as untaxed compensation. The point has force but not nearly so much as its advocates claim. Even without tax subsidy, private insurance premiums would likely be high because of market concentration, generally rising medical costs, strong demand for coverage, and insurer inability to effectively control costs to any significantly better degree than the government.

Regardless of whether it is taxed when received by an employee, the employer's share of group health insurance premiums costs money for the employer. Although the cost can be deducted as a business expense, the corresponding reduction in tax liability is not, for most businesses, the same as avoiding the expenditure altogether. Health insurance still costs

Medicare Meets Mephistopheles, 60 WASH. & LEE L. REV. 1165 (2003) (similar, shorter version of argument).

64. See Hossain, *supra* note 1, at 1 (noting absence of even Democratic presidential support for government single-payer insurance or any plan that does not rely substantially on purchase of private medical insurance). Further, Hyman, albeit sometimes feeling embattled among the ivory tower types, is not without at least partial support in the academy as well. See, e.g., Timothy Stoltzfus Jost, *Our Broken Health Care System and How to Fix It: An Essay on Health Law and Policy*, 41 WAKE FOREST L. REV. 537 (2006) (advocating continued significant role for private insurance along the lines of Massachusetts plan, with purchase mandates but subsidies for payment). See also Jacobson, *supra* note 9, at 734-35 (contending that four conceptual paradigms compete for dominance in health law: economic (market competitive); professional; rights-based (social justice) and institutional, and that "social justice model is on hold" which is a "euphemism for being dead in the water. Instead, the real struggle for doctrinal supremacy in health law is between the market and professional models."). A soundly administered government single payer system holds the more promise than the current or market models for achieving professional and institutional goals as well as social justice and may actually work to enhance meaningful consumer choice regarding medical services.

money, which presumably gives employers plenty of incentive to keep premiums down. In spite of this, premiums consistently rise. Although this is not necessarily the “fault” of the market for employer-insurer health care bargaining, it at least demonstrates the strong limitations on this market as a vehicle for controlling premium costs.

Part of the problem is motivational disconnect between employers, who see medical insurance as an expensive fringe benefit on which to economize and workers who get to use the medical care and would like more, better care. Another part of the problem is that even large employers may not have as much leverage with insurers as necessary to provide effective cost control in the face of insurer drive for profit while individuals are particularly ill-suited to the cost-policing enterprise.⁶⁵ By contrast, the

65. See Robert Pear, *Hard Sell Cited as Insurers Push Plans to Elderly*, N.Y. TIMES, May 7, 2007, at A1; Sarah Lueck, *Private Remedy: Insurers Fight to Defend Lucrative Medicare Business; As Democrats Push Cuts, Trade Group Targets Minority Lawmakers*, WALL ST. J., April 30, 2007, at A1; Milt Freudenheim, *A Benefit for Insurers: Medicare Drug Plan Feeds More Profitable Managed Care*, N.Y. TIMES, Mar. 31, 2006, at C1. See also James Bandler, et al., *CEO Aims to Halt Stock-Based Pay at UnitedHealth; Move Comes Amid Scrutiny Of Options Timing, Gains; Suspensions in Vitesse Probe*, WALL ST. J., April 19, 2006 at A1; George Anders, *Health-Care Gold Mines: Middlemen Strike It Rich; Rewarding Career: As Patients, Doctors Feel Pinch, Insurer's CEO Makes a Billion; UnitedHealth Directors Strive To Please 'Brilliant' Chief; New Questions on Options; Selling Trout for 40 Cents a Pound*, WALL ST. J., April 18, 2006 at A1. Of course, providers also try to extract higher prices and maintain or improve their compensation. See Reinhardt, *Economist's Model*, *supra* note 3. But see Vanessa Fuhrmans, *Withdrawal Treatment: A Novel Plan Helps Hospital Wean Itself Off Pricey Tests; It Cajoles Big Insurer to Pay a Little More for Cheaper Therapies*, WALL ST. J., Jan. 12, 2007, at A1 (example of cost-saving methods originated and championed by provider. Hyman makes this point well in *Mephistopheles* and other writings). See e.g., Hyman, *Patient Bill of Rights*, *supra* note 61. A large part of my problem with Hyman's analysis is his relative overemphasis on provider profit (particularly physician compensation) as compared to the problems of private insurer charges and profiteering, which in my view leave problems of provider compensation (particularly physician compensation) in the dust.

Even more troublesome from my point of view is the differential human cost of provider avarice in contrast to insurer avarice. Provider avarice may increase costs but should mean, at least in theory (and mostly in practice) that patients get more care and more than adequate care. But see Hyman, *Medicare Meets Mephistopheles*, *supra* note 63, at 1183 (“Shoveling money out the door to purchase health care services is, of course, not the same thing as purchasing high-quality health care.”). By contrast, insurer avarice is manifested in claim denial that may lead to severe injury or even death for a patient unable to obtain coverage; see Jane Zhang, *Chronic Condition: Amid Fight for Life, A Victim of Lupus Fights for Insurance; Lost in U.S. Health-Care Maze, Her Coverage Was Ended As Her Illness Worsened; Skipping a \$2,000 CT Scan*, WALL ST. J., Dec. 5, 2006, at A1. But, of course, Hyman is hardly alone in pinning much of the blame for rising medical costs (in my view, more of the blame) on providers rather than insurers who fail to control them

federal government and individual states have bargaining clout exceeding that of even large companies. Even a small state (e.g., Nevada) has more employees than even the largest multinational companies. In addition, of course, insurance administered through a national government or 50 state administrations would be significantly more streamlined than insurance purchased through tens of thousands of companies (some large, some small) and administered by scores of health insurers.

Just as employer-insurer bargaining has not been the anticipated cost control panacea regarding premiums, bargaining between insurers and medical providers has not controlled costs to the degree anticipated by defenders of private medical insurers. It is not at all clear that insurers are particularly effective at controlling medical costs in a consistent and rational way.⁶⁶ In spite of the central role of private insurers in the current medical care system, medical costs continue to rise, despite some occasional brief periods of relative stability. By comparison, the health care systems that stop with the half-measures of the American status quo and move directly to the government single-payer system have significantly lower per capita medical costs.⁶⁷

The evidence on insurer cost control is mixed. For example, insurers have been effective in negotiating provider discounts, at least this appears to be the case on the face of benefits explanation statements commonly sent by insurers to policyholders. A typical one indicates that Doctor X charged \$85 for an office visit but discounted it to \$45 in order to receive insurer payment. Even with my \$20 deductible, Doctor X has, at least in theory, reduced his charges because of the presence of private insurance in this medical care transaction.⁶⁸

(particularly the particularly avaricious) and for often establishing economic incentives that are at least as misguided as anything the government could dream up; see e.g. Bruce C. Vladeck, *The Political Economy of Medicare*, HEALTH AFF., Jan./Feb. 1999, at 22.

66. See Rhonda L. Rundle, *Critical Case: How an Email Rant Jolted a Big HMO: A 22-Year-Old's Tirade Made Trouble for Kaiser; Mr. Deal Got Fired, Famous*, WALL ST. J., Apr. 24, 2007, at A1 (whistleblower notes \$1.5 billion annually in alleged waste expenditure by insurer on misconceived electronic records project); John C. Goodman, *Perverse Incentives in Health Care*, WALL ST. J., Apr. 5, 2007 at A13 (noting that Mayo Clinic may be cheaper than your local hospital).

67. See *supra* note 18.

68. Random walks through recent family medical bills reflect similarly deep discounts, at least on paper, for other services. For example, one specialist lists a charge of \$220 for a comprehensive new patient visit, but accepts \$96.72 from my insurer, "adjusts" the charges to eliminate \$93.28 (effectively eating this portion of the charge and in effect knocking the \$220 charge to \$130, leaving \$30 as the patient's portion. For an ultrasound done separately for the examination, the list price is \$175, for which the insurance company

Alternatively, Doctor Y may be unwilling to discount the retail price of an office building but has patients who prefer Dr. Y or doctors with a similar practice style and unwillingness to make deep discounts for insurers. Dr. Y may simply bill the patient for whatever portion of the bill the insurer does not cover. In effect, this subjects the patients of Dr. Y (e.g., me) to a 50 percent co-pay, a financial burden I am happy to bear for relatively lower cost medical needs of this magnitude. I don't shop for a cheaper doctor or one more willing to make the insurer's proffered discount because I prefer Dr. Y, who on average spends triple the time with me during an office visit than my previous family physician and also is willing to be involved with any hospitalization of patients.

pays \$68.54, the doctor absorbs \$89.32 and I am billed \$17.14. The math looks about right, but I am not about to verify by taking the time to dig into the fine print of my group policy nor am I going to call a representative of the TPA that my employer's plan has retained to process claims. The final tally of \$47.85 billed to me (there were some small lab charges as well) seems reasonable in relation to the \$405 retail price listed on the doctor's invoice and leaves me paying the traditional 20 percent co-pay. So much for the power of patient consumerism. Because I was seeing the doctor over a relatively acute medical issue (an infection), bypassing medical care was not an option and, knowing that all doctors of this specialty generally charge roughly the same rates, I was unlikely to price shop as well. Nor would I be deterred by the 20 percent co-pay. The deterrence was the time and inconvenience of seeing the doctor. If I had not been previously told (based on a routine blood test) that I had an infection (accompanied by considerable symptoms of discomfort), I would gladly have skipped the trip to the doctor. So much for moral hazard.

A less extreme example of discount billing with reduced monopoly money character of U.S. medical insurance was reflected in a recent family bill for oral surgery, specifically the extraction of four wisdom teeth from my older son's mouth. The dentist charged \$1,465 (\$285 for general anesthesia, and \$295 per tooth. Of this total, the insurer paid 1,052, I paid \$313, and the dentist absorbed \$100 in discount.

Again tending to refute the picture of the world painted by market/consumer-oriented commentators, I was really pretty indifferent to both the doctor's suggested retail price and the degree to which the insurer extracted pricing concessions, even though this was not emergency surgery. This was the dentist my son and I wanted to use based on the experience of his siblings (one with this dentist and another having a less successful wisdom teeth extraction with another well-regarded dentist in town). I did not think \$1,400 was a particularly high price to pay for all this dental work, which required not only the time and skill of the oral surgeon but also specific and general staff assistance, considerable fixed office overhead (e.g., special equipment), and variable costs such as general and local anesthesia, gauze, surgical thread, etc. My \$300 payment seemed more than reasonable, again paralleling the customary 20 percent co-pay, but I would hardly have blinked if the figure had been \$400 or \$500.

See also Hyman & Silver, *supra* note 61, at 966 (largely positing substantial efficacy of private insurers in controlling prices but castigating them for not caring sufficiently about quality of care delivered). *See also id.* at 981 (noting that medical malpractice insurance is "rarely risk rated") (footnote omitted).

According to the market/consumer-oriented approach, I am not enough of a bargain hunter. In this realm, I am behaving more according to the professionalism paradigm of medicine than the market competition paradigm. I value more thorough professional treatment more than a reduced price tag. Once again, my own experience suggests that much of the view of patient behavior posited by those promoting the consumer-oriented approach does not accurately reflect actual patient behavior, at least for those with means or insurance.

In addition, something about the deep discounts given by providers to insurers is uncomfortably reminiscent of the property tax statements we all also receive as homeowners. A typical such statement gives an assessed value of the home that, even after the post-2005 housing downturn, is generally substantially lower than the actual current fair market value of the house. Thus, a tax rate per \$1,000 of value that would seem unduly confiscatory if the home were valued at current market prices becomes a sufferable tax burden when applied to an artificially low value carried on the assessor's books.

In similar fashion, the net cost of a medical service may be discounted only as a matter of cosmetics. If provider discounts are a part of the game of insurer-provider interaction, the situation evolves to one in which the provider's list price is intentionally inflated in the knowledge that the insurer will impose a discount. In order to get his \$45 payment from the medical insurer, Doctor X charges \$90 for what would have otherwise been a \$45 charge (or \$65 if the patient's co-pay is viewed as a sort of subsidizing middleman were eliminated from the equation).

My own view is that \$90 for a routine office visit to a family doctor is high enough to border on the excessive, despite the high overhead of running a doctor's office, if the doctor is applying the business school rule of thumb that a doctor's "encounter" with the patient should be no more than seven minutes. Extrapolated, this results in an hourly rate of compensation for the doctor exceeding \$700, a rate comparable with top partners in commercial law firms, which have high overhead resembling that of a doctor's office.

However, if the doctor is seeing each patient for 15 minutes on average, the doctor's gross hourly rate is less than \$400 per hour, a rate comparable to that of top business lawyers in many cities and a higher rate of pay than found in most occupations. However, the net income to the doctor from this hour of work will be considerably less, perhaps even a comparative pittance, depending on the doctor's overhead costs, which may be substantial, in some part because of expenditures required for dealing with private and government insurers. Understandably, even the most

professional of physicians is tempted by the thought of shorter patient encounters and greater profits. Spending 10 minutes per patient instead of 15 minutes per patient results in a 50 percent increase in gross income (to \$600/hour). But if overhead costs are not too high, doctors can earn quite a good living and still give each patient on average 15 minutes of their professional attention.

The case that per-service charges and compensation to medical providers are on the high side becomes stronger when one examines the rate of insurer payment for medical procedures, which can involve thousands or even tens of thousands of dollars for a 45-75 minute surgery. Much depends on the locality, the procedure, and the insurer. Similarly, Medicare reimbursement rates vary widely by state.⁶⁹ In spite of the higher overhead for surgery (as compared to an office providing patient examination), these compensation structures can make Wall Street lawyers look cheap. But it may also be the case that the surgery reimbursement rates are modest in light of the time, skill, training, and overhead required for performing a procedure. As previously discussed, one can in my city get wisdom teeth extracted from a highly regarded oral surgeon for a list price of less than \$300 per tooth. Less prestigious dentists in town may charge as little as \$145 per tooth.⁷⁰ This is not a lot to spend for an important, one-time medical-dental event designed to minimize or avoid future problems.⁷¹

Hospital charges are, from my own experience, more problematic. Hospital charges of \$2,000 per day are not uncommon, with much of the cost of medical care received while staying in a hospital separately billed at

69. See Hyman, *Mephistopheles*, 60 WASH. & LEE L. REV. 1165, *supra* note 63, at 1179-81.

70. See *supra* note 68. As some point, too low a price for wisdom tooth extraction should presumably raise concerns about patient safety. Unless the doctor charging \$145 per tooth simply has an Albert Schweitzer-like preference for lower income, it is more likely that he has fewer or less experienced office staff, less modern equipment and facilities, and a business model that requires greater speed in performing the operation and releasing the patient. All other things being equal, this has to increase the risk of adverse outcomes for the patient. The dividing line between safe-but-no-frills extraction and unduly risky extraction is one best made by trained professionals and competent regulators untainted by undue financial incentives. But at some point, cheaper medical care becomes less safe medical care. For example, poorly done wisdom tooth extraction can damage nerves, gums, other teeth or result in undue bleeding and severe infection as well as a painful "dry socket."

71. But the medical cost-legal fee dichotomy breaks down somewhat. For example, expensive lawyers are generally retained and paid by business entities that deduct the cost from their taxable income. Individuals only have this luxury if medical expenses exceed 7.5 percent of gross income in a given year.

a separate time. In spite of the cost of physical overhead, nursing services, and liability insurance that a stay at the hospital somewhat different than grabbing a hotel room, this is a lot of money to spend for in essence parking a patient in a spot with access to medical facilities and nursing care personnel. If private insurers can force doctors to take 50 percent discounts, one wonders why similar cost reduction has not been imposed on hospitals.

Viewed broadly, it appears that private insurers standing in for individuals undoubtedly restrain medical care costs to a significant degree. But they are hardly great price-busters in this regard. More important for purposes of the medical insurance debate, there appears to be no reason that a government entity policing medical charges could not perform the price control function as effectively as private insurers. In practice, it appears that the Veteran's Administration, Medicare, and Medicaid all do comparably well in this regard as compared to private insurers.

If nothing else, a quilt of private insurance funding much of health care logically imposes greater expenditures than a government plan simply from the higher administrative costs associated with documenting services, claims, and payment involving so many insurers who have different forms, procedures, and protocols. Typical doctor's offices devote more than half their overhead simply to the administrative and paperwork burdens imposed by the current system. In effect, we have a system that acts as something of a private full-employment measure by requiring the hiring of several persons who do not actually provide medical services in order to support a single person or handful of persons actually offering medical services. In the private health insurance world, bureaucracy and paperwork dominate to a degree that few government agencies can match.⁷² For

72. Again, to me, personal and shared experience is as telling as any statistical report. As one example, I have a friend with a spouse in need of mental health care. Although her group insurance policy clearly covers these services, the claims administrator (which was retained by the managing general agent (which was retained by the self-insured employer's group insurance plan) has repeatedly, erroneously refused treatment, incorrectly claiming that the spouse must be in an "acute" ready-to-jump-off-a-bridge mental state. After many hours of phone calls and emails, my friend finally reached someone in the MGA office who confirmed that indeed there was coverage under the policy. However, to effectuate treatment, she is again required to go through the same claims administrator that continues to claim non-coverage even though this issue has been decided favorably to the insured. It is hard to imagine a government agency doing a poorer, more wasteful job of determining coverage and policing the receipt of medical benefits. Cynics among us might wonder whether this is in fact part of a larger conspiracy (tacit or explicit) to delay treatment and

hospitals, the ratio of medical to administrative expenses is somewhat lower, but largely only because the cost of medical services at the hospital (e.g., surgery, intravenous feeding, intensive care) dwarfs the costs of the less intense medical care administered in a doctor's office. Further, if one considers the provision of a basic room and bed to be administrative overhead rather than medical services, the hospital ratio of overhead to medical costs would be high. By contrast, government programs offer a consistency and streamlining superior to that of the current status quo affecting most insureds.

Reduction of paperwork provides the opportunity to deploy the savings in administrative costs for most substantive expenditures such as more useful treatment or better compensation of medical professionals who

payment or to discourage insureds from using mental health services that they literally have paid for in advance through insurance premiums.

Closer to home is my daughter's experience with physical therapy after knee surgery. Pursuant to a doctor's prescription (actually several over time), she has been receiving therapy for some months. Throughout this time, I have received scores of form letters informing me that my insurer cannot determine whether to pay its portion of the cost until it receives further information. The insurer claims it does not have the prescription(s) on file while the provider claims it was sent weeks earlier. Eventually, the provider and the insurer agree that these indeed are properly covered and documented services, although there has been for me some lost time from work making calls or writing letters.

For example, as this was being written, I received in the mail a thick envelope from my insurance plan's claims administrator containing 30 separate forms (plus an additional two forms arriving under separate cover in the same day's mail) indicating that, after all the dust had settled, my insurer was covering the physical therapy. I am course happy to be covered without dispute and to have my daughter receive needed post-operation physical therapy. But was it even remotely necessary to kill so many trees and incur so much administrative expense in coming to that decision and communicating it to me?

In effect, the bottom line is the same. But due to these miscommunications and delays, approximately 70 of my daughter's PT sessions have resulted in insurer-generated letters and "explanation" of benefits that needlessly kill trees, require postage, distract me, and require filing. Meanwhile, the provider waits weeks or months for payment, which may explain part of why the cost for a simple physical therapy session is (at least by my reckoning) shockingly high (both in stated retail terms and after discount). Of course, the delay and extra expense may be the provider's fault. But an efficient insurer would presumably find some way to avoid at least some of this seemingly needless expense.

It is hard to imagine a government single-payer system creating more waste for in connection with a claim that in the final analysis is covered as part of routine insurer operations. Nor does the private insurer/claims manager appear to be any better at communicating than much-maligned government bureaucracies. For example, the typical letter of this type I have received in connection with my daughter's physical therapy informs me that this is a "2nd Notice" (even when it is the first notice) and that I must "[p]lease respond in 30 days." A few lines later, I am told that "[n]o action is required of you at this time."

might otherwise be unwilling to perform services for the payment rates promised by private insurers. For example, an increasing number of physicians will not accept private insurance (or at least certain types of private insurance) but will accept Medicaid or Medicare patients. In effect, this portion of the market of medical providers is refuting market-based defense of the status quo and demonstrating that for doctors there is nothing inherently superior about dealing with a private insurer as compared to a government insurer.

Perhaps the biggest elephant in the room for advocates of increase market-based, privatized, or consumer-driven health care is the simple fact that the United States long ago stopped resembling anything close to a pure market-based model for the delivery of medical care.⁷³ In spite of this “[t]axpayers . . . don’t get as much bang for their bucks because the government guarantees coverage for the elderly and the poor, groups that account for a disproportionately large amount of expenditures.”⁷⁴

Most obviously, we have Medicare and Medicaid and the VA and the Federal Employees Insurance Program as well as the de facto insurance of emergency room care that, for the uninsured, becomes subsidized or even “free” medical care, the costs of which are externalized on the medical community and society at large. This coverage accounts for 40 percent or more of the medical coverage provided in the country (and perhaps even more of the total expenditures on health care). Medicare is politically popular and will as only expand as the population ages. Medicaid, like most programs designed for the needy, has a less powerful political base but seemingly also one that can withstand attack. The VA enjoys similar

73. See Daniel Gross, *National Health Care? We’re Halfway There*, N.Y. TIMES, Dec. 3, 2006, §3, at 4 (stating that 38 percent of medical expenses in U.S. are publicly funded; “[t]he government spends money as if there were a national health insurance program. In 2004, government spending on health care equaled 9.6 percent of the gross domestic product, compared with 6.9 percent in Canada, which has a single-payer universal health care program,” (quoting Harvard Medical School Professor David Himmelstein); considering all expenditures “government accounts for about two-thirds of health care spending” (quoting Princeton University economist Uwe Reinhardt)). *Accord*, Anna Bernasek, *Health Care Problem? Check the American Psyche*, N.Y. TIMES, Dec. 31, 2006 §3, at 1 (in U.S., government share of total medical care spending is 45 percent). See also Bobinski, *supra* note 13 (“In 1987, the public and private share of health expenditures were the mirror image of the distribution found in Canada, with the private sector picking up 70% of the costs of health care and the public sector paying for 30%. The public share of health care expenditures [in the U.S.] grew to 40% in 2005 and remained stable in 2006”)(footnotes omitted).

74. See Gross, *supra* note 73 (“A rough rule holds that private insurance covers two-thirds of the population and pays for only one-third of all health care”(quoting Reinhardt)).

support. Although no one likes the use of emergency room visits as a substitute for regular health care (rather than true, acute emergencies or medical problems taking place at night or on weekends), political and social sentiment continues to weigh against giving Hospital ERs the prerogative to refuse services

In addition, even the supposedly more private and market-oriented half of American health care is a far cry from ordinary retail selection, purchase and consumption. Beginning with the use of health insurance coverage as a means of escaping the strictures of World War II's wage and price controls, we have replaced individual fee-for-services purchase of medical care with not just an insurance-based system but one dominated by large group plans that are only "chosen" by policyholders at the margin. As this system has evolved, it has become, as well described by Nan Hunter, into "employer corporate sovereignty in the formulation and administration of risk pools for group health insurance in the workplace."⁷⁵ Although this may be "private" (in that it is done by employers and non-government group insurers), it is not so much a market as a negotiated form of private legislation.

Advocates of greater efficiency in health care pricing and delivery can muster a number of good arguments against a greater government role and against government subsidization. But in addition to the problem of overlooking the humanitarian concern that adequate health care seems to many of us more a right than a consumer preference, the conservative side of the health insurance debate founders on empirical shoals. Political sentiment will almost certainly prevent any retrenchment of the existing governmental presence in the medical coverage status quo. Only a minority of voters seem to get enthused when political candidates rail against socialized medicine and only a few of even those that do have been willing to support any significant curtailment of the existing systems. Most voters want to at least maintain the government presents that already exists. That sentiment will only grow stronger as more voters reach age 65 and the total medical costs of the Iraq War and Afghanistan intervention continue to roll on for years to come.

Because of this political reality, conservatives will never again see an open market world regarding the purchase and delivery of medical services. Consequently, many of the proposed conservative remedies for current health care problems are simply not likely to be effective. They cannot

75. See Nan D. Hunter, *Risk Governance and Deliberative Democracy in Health Care*, 97 GEO. L.J. 1 (2008).

supplant the current mixture of public and private with a tabula rasa that permits the purported full flowering of benefits they posit from a private market model. Consequently, they are reduced to proposing incentives for more efficient behavior or isolated market-mimicking initiatives such as health savings accounts.

As Tim Jost persuasively argues, HSAs appear largely a government subsidized benefit to the healthy and wealthy.⁷⁶ This is hardly the return of the free, private market. Rather, it looks instead like successful rent-seeking by interest groups (the wealthy, banks, and insurers selling the high-deductible catastrophic plans that accompany HSAs). Since the nation is not overrun with wealthy people in good health looking for tax shelters and humans are not the posited rational option maximizers consumed with financial planning, the predicted boom in HSAs has been slow to materialize, suggesting that they are not the panacea painted by their advocates.⁷⁷

The second empirical shoal upon which the conservative ship founders is the experience of other industrialized nations. As previously noted, Canada and Western Europe, after embarking on national government-run plans for universal coverage, have never retreated from that goal. More important, as also previously noted, the per capita costs of medical care in those nations is dramatically lower than the U.S. and their citizenry appears to be at least as health as that of the U.S.⁷⁸ Simply put, one must ask the

76. See Jost, *supra* note 4.

77. See Vanessa Fuhrmans, *Health Savings Plans Start to Falter; Despite Employer Enthusiasm for Consumer-Directed Approach, Patients Express Dissatisfaction With How the Accounts Work*, WALL ST. J., June 12, 2007, at D1.

78. See Timothy Stoltzfus Jost, *Private or Public Approaches to Insuring the Uninsured: Lessons From International Experience With Private Insurance*, 76 N.Y.U. L. REV. 419, 437-39 (2001) (noting higher costs of U.S. system as compared to those of other countries); Justin Lahart, *Rethinking Health Care and the GDP*, WALL ST. J., Jan. 25, 2007, at C1 (noting dramatically higher costs per capita of U.S. System but U.S. measuring worse according to life expectancy, infant mortality, and other metrics); But see Tyler Cowen, *Abolishing the Middlemen Won't Make Health Care a Free Lunch*, N.Y. TIMES, Mar. 22, 2007, at C3 (contending that full amount of medical overhead costs in Europe and Canada is systemically understated in cost comparison studies because of failure to consider longer waiting times for some services in non-U.S. countries, which shifts in-kind overhead cost to consumer and also arguing that European systems are less responsive to paying for new treatments and drugs); Froma Harrop, *Canada's the Wrong Model for Universal Health Care*, SEATTLE TIMES, Feb. 28, 2007, available at http://seattletimes.nwsources.com/html/opinion/2003592432_harrop28.html (referring to study by Fraser Institute, an organization that "promotes privatization" as finding Canadian system "wanting" in comparison to others but failing to provide concrete examples).

question: If movement toward greater privatization, market competition, or personal choice is so wonderful, why have these other nations not moved in this direction? And why has there failure to make any such movement not seemingly harmed health care in those countries relative to the more privatized, market-based, consumer-driven United States?

III. THE INEFFICACY OF INSURERS IN ACHIEVING FAIR COST CONSTRAINT

Another aspect of Adam Smith's legacy in the U.S. is a widely held belief that the private sector is always considerably more efficient than the public sector in accomplishing goals.⁷⁹ Applied to medical coverage, this mythology posits that private sector insurers play a vital role in controlling health care costs that stems from the private sector's greater talent in achieving efficiency. A significant fear standing in the way of movement toward government as single payer is that health care costs, already rising well faster than inflation, will be even less effectively checked by government than it has been by the private sector.

The mythology of Smithian invisible hand efficiency is so strong that its advocates conveniently overlook the degree to which much of the American economy has implicitly found that in many instances,

Both the Harrop and Cowen op-ed pieces reflect the type of rhetorical shortcut that often substitutes for analysis in the health care debate. Harrop quotes the Fraser Institute founder saying that "If people don't have to dig into their own pockets when they use medical services" "you find yourself giving universal access to a physician for sniffles and company." Cowen makes a more sophisticated but similar argument that "patients and doctors will try to get the most out of any system. When they aren't paying directly, patients will seek extra care and doctors will be happy to oblige." (also analogizing overuse of medical services as akin to shoplifting items in a retail store).

This is the standard, overblown moral hazard analysis dumbed down to a homey phrase. But does it really measure the inclination of more than a micro-majority of consumers? Every person I know (including non-working adults and students) finds going to the doctor (even when quite sick) to be a great inconvenience that exacts a heavy price in time and energy even without a co-pay or deductible. They only go to the doctor when they feel they have a real need. For sniffles, they would rather have the additional time at work or to rest at home rather than parking themselves in a doctors' office after breaking up their day to travel there. On this issue, much of the resistance to comprehensive government-administered insurance appears to come from those who hold a warped picture of the real world. Although over-utilization by a fully insured population is a danger at the margin, it hardly represents normal patient behavior.

79. Bernasek, *supra* note 60 ("[c]hanging the minds of so many millions of people isn't done overnight. But sooner or later, persuading people to do something that's in their own economic interest ought to succeed.").

government regulation in derogation of private markets has been necessary for sound and efficient economic and social policy. Occasionally, even government operation of certain activities may be more efficient than regulated or unfettered market activity. For example, we have largely forsaken the invisible hand in the cases of utility provision (gas, electricity, water), transportation (roads and mass transit), airports, cargo hauling, military procurement, and infrastructure generally.

One can view the provision of adequate health care as an infrastructure problem. Like many such problems, it is best solved by government intervention (and funding) to create the infrastructure platform, which in turn decreases administrative costs, provides consistency, and increases social productivity. Efforts initially perhaps seen as in derogation of Smith's invisible hand thus ultimately help create an environment in which markets and productivity can flourish beyond what would occur in the absence of adequate infrastructure.

This portion of the health insurance problem also reflects another legal friction or inconsistency in attitudes. On the one hand, the public wants to hold down health care cost increases. But on the metaphorical other hand, the public appears unwilling to embrace many cost-containing measures. For example, health costs during the 1990s were relatively stable but this appears to have resulted in significant part from the limitations on care imposed by HMOs. Many insureds chafed at these restrictions and their discontent fueled policy measures restricting HMO gatekeeping or mandating benefits. Although the reining in of HMOs may not have been the sole or even prime cause, health care costs began to rise again significantly in the late 1990s and early 20th Century.

Critics of a national medical insurance plan have at least something of a point: if left to their own devices, consumers will take and take and take when it comes to medical care, at least if they are not paying sufficiently directly with their own money. Consequently, they argue, under a government funded and administered system, individuals will lack adequate incentive to control themselves and will consistently opt for more treatment when less would suffice. Hydraulically, this drives up the cost of health care (quite substantially in the aggregate) unless it is tamped down by a gatekeeper.

Defenders of the current model argue that the private insurance industry does this better than government. Although some of the "proof" for this assertion is essentially a second bare assertion that government is always more wasteful than the private sector, defenders to the status quo can point to government reaction to HMO controls as an example of the government's greater sensitivity toward consumer sentiment. Insurers

argue, at least implicitly, that his is bad because it gives government insufficient backbone to control health care costs, by rationing if necessary and that by contrast the insurance industry, fueled by the profit motive of Smith's invisible hand, has the fortitude to hold the line on costs (or at least hold the line better than the government).

This is not an unpersuasive or illogical argument. However, it ignores two substantial problems. First, advocates of holding the line on costs appear not to recognize that holding the line is not always a good thing. Sometimes, some things are worth a higher price in order to better provide the good or service in question. Sometimes this is for utilitarian reasons: doing something right will increase productivity further down the line. Sometimes, this is for humanitarian reasons: doing something right is worth simply to provide better, more humane treatment to patients.

Government regulation banning "drive-by" deliveries of babies (so named because insurers would not pay for more than 48 hours of hospital care after a delivery, and hospitals tended to seek discharge within 48 hours even if individuals were willing to pay for longer stays) provides a good example. In his previous writings, David Hyman has attacked these regulations with a sustained ferocity usually reserved for Red Sox fans talking about the Yankees.⁸⁰ In his contribution to this Symposium, he again makes the argument that these regulations needlessly increased hospital stays and medical costs, resulting in a corresponding increase in medical insurance that encouraged shrinkage of coverage.⁸¹

I have quite a different view, one formed in large part as a result of my wife's experience with three baby deliveries, all by Caesarian section. Although Hyman would undoubtedly criticize this as argument by anecdote, I think the points made by reciting my own family experience make a useful point. Further, although policymaking that is too driven by anecdote of course is dangerous, it is equally dangerous to lose sight of the application of policies by paying insufficient attention to personal experience and giving exclusive focus to aggregate data that may obscure or minimize the consequences of practices on the ground. Josef Stalin was not addressing medical insurance when he infamously uttered that "a single death is a tragedy; a million deaths is a statistic." But he could just as well have been. It may be a mistake to legislate on the basis of a single moving

80. See David A. Hyman, Commentary, *What Lessons Should We Learn from Drive-Through Deliveries?* 107 PEDIATRICS 406 (2001); Hyman, *Drive-Through Deliveries*, *supra* note 61.

81. See Hyman, *Government Failure?*, *supra* note 4.

personal story. But it can be just as mistaken to legislate (or refrain from legislation) based on aggregate data that glosses over the daily operation of medical care and insurance for real people.

My story (or rather, my wife's) is not tragic and moving in the manner of a patient's needless death due to malpractice or lack of even achieving patient status because of lack of insurance, but it is instructive. When our first child was born, there was a long, difficult delivery in which, after 20 hours of labor, the medical professionals concluded (about 12 hours too late for my taste, but that was the orientation of this practice) that Caesarian section was necessary for a safe birth. Surgery successfully occurred in the wee hours of the morning and a healthy baby emerged. Mom was exhausted, looking and feeling a bit like someone who had been in a marthon boxing match.

Nonetheless, the hospital gave us the bum's rush out after a two-day stay in the hospital.⁸² We were comparatively young, unsophisticated in these matters, and probably should have fought harder to stay in the hospital for two days (perhaps more) of much needed rest and care. I even made an attempt at offering to pick up the extra care out of personal funds. The hospital was distinctly uninterested in working with us. If the insurance would not pay for more than 48 hours of post-op care, it seemingly wanted us out, in spite of our middle class ability to pay. So much for consumer-driven health care.

Back home, the consequences of a rushed, abbreviated stay in the hospital were palpable. The new mother, still physically exhausted from delivery, was now attempting to recover from the wounds of a C-section at home while caring for a newborn. Although the dutiful husband did his semi-competent best to manage care for baby and mother, this was a far cry from the type of rest and care both would have received from the hospital. It took weeks for my wife to recover sufficiently to do anything of modest strenuousness. Anecdotal or not, I remain convinced that she would have returned to her normal energy, health, productivity much sooner if she could have only had a few more days in the hospital.

82. Which means that we were accorded less coverage (and less maternal recovery time in the hospital) than even if we had been subject to a standard "drive-through delivery," which Hyman defines as the practice of discharging women and newborns from the hospital less than forty-eight hours after a vaginal delivery and ninety-six hours after a Cesarean section. See Hyman, *Drive-Through Deliveries*, *supra* note 69, at 9. Consequently, our family medical insurance situation would have been helped significantly with legislation that did not go as far as the Newborns and Mothers' Health Protection Act of 1996. 42 U.S.C. § 300gg-4 (2003).

In addition, the newborn in question (our elder son) at age three weeks developed a viral infection, exhibited meningitis-like symptoms, and was hospitalized and given considerable medical care for days before recovering, which of necessity took mom and dad further away from work and productivity. Although proving a link between my son's severe problems at age three weeks and the shortened hospital stay is impossible, I can't help but think that his mother's bedraggled condition on discharge, which made for lactation and nursing problems, which in turn posed nutrition and immunity issues for the baby, might have played a role. In any event, what resulted was a 4-5 week period in which two previously productive adults were largely out of commission in at least some part due to the supposedly cost-saving, efficient mechanism of kicking new mothers to the curb two days after a particularly rough delivery and C-section birth.

When subsequent children arrived, C-section was also required. By then, we were a little more sophisticated and assertive (and had broader insurance coverage and better medical care). In addition to performing the operations much earlier without physically punishing the mother for hours, additional hospital recovery time was obtained. Maternal recovery and new baby care proceeded far more smoothly and effectively. Neither of the children had any post-partum health problems and both Mom and Dad got considerably more done during the ensuing five weeks after these deliveries than was the case with the first delivery.

With this personal history, it is understandable that I was never a fan of drive-by deliveries and was thrilled to see government intervention to stop them. Notwithstanding Hyman's cogent (if perhaps overheated) arguments of net policy detriment, I remain a fan of this regulation. Although it will not always result in greater family productivity and reduced overall medical costs, I am convinced that in many cases giving a new mother and baby a couple more days of hospital care (while the often hapless husband also has more time to get the home situation under control) will have that effect. More important, it is simply a more humane way to treat new mothers and children. American society regularly purports to value families. Providing an additional increment of medical care – or at least removing the incentive for hospitals to rush patients home – is a small price to pay in the service of those values.

A second problem with the conventional wisdom (that the private sector controls costs much better than the government) is that considerable evidence exists to suggest the sentiment is overblown or perhaps even erroneous. At the least, it appears that private insurers do an inconsistent job of holding the line. More important, it is to me unclear whether private insurers do any better job of cost containment than does the government.

Alternatively, if private insurers do too much better than the government in holding down the price of medical services, this may create incentives that undermine the availability and provision of sound medical care.

As previously noted, private insurers have been able to extract from medical providers significant discounts from what the provider otherwise states as the “list price” for a medical or laboratory service. This may simply mean that medical pricing has become like automobile shopping. The “sticker price” exists only as an outside anchor or measuring stick but no one really pays this list price (except the rare uninsured patient who actually has independent financial resources). For purposes of argument, I will give credit to insurers for actually enforcing some type of real price constraint about medical providers. At the very least, one certainly hears doctors consistently complain about the low payment rates provided by insurers.⁸³

The question then becomes: does the private insurer do a better job of payment-for-services containment than comparable government programs. Here, the evidence seems mixed. Insurers may be doing a pretty good job of keeping doctors from charging exorbitant amounts (even if they are also encouraging doctors to provide assembly-line care). But Medicare and Medicaid also appear to be effective in tamping down costs-per-medical service. And the VA, with its system of staff physicians on salary, may be the most efficient of all in controlling doctor-related costs. Even where the insurer suppresses provider rates more than does a government payer, this hardly means the net benefit to patients and society is greater. Excessive cost cutting may lead to unwanted collateral consequences.⁸⁴

83. Doctors also differentiate among insurers. Many refuse to see patients insured by carriers whose payment rates are simply too low. One former internist of mine explained he rejected patients covered by the HMO then known as US Healthcare because it paid “coolie wages” for office visits. Whatever the political incorrectness of the comment, it is a pretty good reflection of the way many doctors today do business. They will work with some health insurers but not others based on the amounts paid for service, the administrative burden, and the overall difficulty of working with some providers. Other physicians may take an “all comers” attitude, assuming that by seeing enough patients fast enough, they can make more money than if they simply avoid the stingiest, most difficult insurers altogether.

84. The same, of course, can be true for excessive imposition of costs. See Stephen Dubner & Steven D. Levitt, *Unintended Consequences, The Case of the Red-Cockaded Woodpecker*, N.Y. TIMES, Jan 20, 2008 (Magazine) available at http://www.nytimes.com/2008/01/20/magazine/20wwln-freak-t.html?_r=1&oref=slogin.

Dubner & Levitt, in an installment of their now well-known “Freakonomics” feature in the *Times* (see also STEPHEN DUBNER & STEVEN D. LEVITT, *FREAKONOMICS: A ROGUE ECONOMIST EXPLORES THE HIDDEN SIDE OF EVERYTHING* (William Morrow 2005)), give the example of a deaf patient consulting an orthopedic surgeon and insisting on her

Clearly there is inherent tension (legal friction once again) between the goal of making provision of quality medical services economically attractive to prospective providers and holding back runaway medical costs. Hyman's resolution of the tension is largely against medical providers and in favor of insurers and the posited cost-controlling force of more empowered consumers. In addition to disagreeing with Hyman about the actual efficacy of consumer constraint, particularly where the consumer is too poor or uninsured to have much clout, I question whether excessive payment to providers, particularly doctors, is the culprit.

Consider my eye doctor, who in addition to being very competent is also professional in the classic sense. Although he is repeatedly identified as one of the best doctors in the area in local magazine's "best of" features, he carries a comparatively low patient load, spends significant time with each patient, and has an uncrowded waiting room. He accepts Medicare but not many private insurers, where he not only has found the reimbursement rate too low but also has found the private insurers' paperwork and bureaucratic hassle to be too much for his staff. He also expresses support for a comprehensive single-payer system along the lines of Medicare and suspects that a large portion of doctors, particularly younger doctors less reared on the traditional AMA stances against "socialized" medicine, agree with him.

right (per the Americans With Disabilities Act) to a sign language interpreter so that she could better understand the doctor's diagnosis and recommendation. In the Los Angeles metro area where this took place, a qualified interpreter generally charges \$120/hour with a two-hour minimum, an amount required to be borne by the physician and which the patient's private health insurer refused to cover. Not surprisingly, the good doctor who initially accepted this needy patient and then was hit with unexpected interpreter charges made no money on this patient. His solution and that of similarly situated doctors in the future will be to attempt to avoid taking such patients. *Id.*

The episode serves of course as a good example of the occasional incidence of negative unintended consequences from well-meaning legislation. In addition, it serves to illustrate the degree to which too much of the modern health care burden has been placed on doctors relative to insurers. Further, it provides additional support for a government single payer system. Imposing translator costs on a single doctor, or even a medical group or hospital, has great potential for unfairness simply because of the fortuity of when a deaf prospective patient may approach a particular provider seeking medical care. Imposing mandatory coverage on a single private insurer is a better approach but still may result in lopsided distribution of the added costs of improving the access and experience of the deaf seeking medical care. But if the coverage is provided by a national government single payer system, the added costs of translation are spread as broadly as possible and amortized among many beneficiaries of the medical-economic system. This optimal risk spreading seems the fairest solution as well as one efficient in administrative terms and unlikely to deter any particular deaf patient from seeking and receiving desired care.

Regarding costs: when he first began performing cataract surgery, he reports that the Medicare reimbursement rate was approximately \$1,200 and that of private insurers was about \$1,100. Notwithstanding the aggregate data about overall increase in medical costs, he has seen the rate of payment for cataract surgery go down (at least in Las Vegas) to a current rough range of \$600 - \$900, depending on the insurer. Medicare pays about \$750. In a world where a visit from the plumber or electrician routinely results in minimum bills of \$125 or more, this hardly seems like excessive compensation for the doctor. Purchase of cataract surgery logically should cover not only the doctor's actual time and skill in performing the procedure but must provide reasonable contribution to defraying his overhead and recoupment of investment in human capital such as medical school and additional training and education.

Successful cataract surgery of course dramatically improves the patient's vision and quality of life and probably improves their economic productivity as well (even though many cataract patients are older and retired). Compared to other expenditures, particularly those for personal services,⁸⁵ paying \$750 to the doctor for the procedure does not seem like price gouging or an otherwise bad deal. More important, if high quality physicians are reluctant to discount their prices below this amount, trouble can ensue. Perhaps less competent doctors will be the ones performing the \$600 cataract surgeries. Or perhaps the doctor will make sure he takes on additional patients and schedules an additional procedure or two on surgery days, even if this results in more error due to haste or mistakes born of tiredness.

85. Economies of scale are easier to achieve with manufactured goods than with delivery of even relatively routine personal services. For example, once the mold has been established, a manufacturer can crank out I-pods or televisions at a lower cost per additional unit than even the most rushed, robotic surgeon. Personal services of necessity require investment of at least a minimum amount of time and present individual variants not found in manufacturing. Every defective plumbing joint or electric socket is a bit different while mass-produced goods are not. As a result, an I-pod that lasts for years can be sold for \$300 but the same amount of medical care quickly disappears into the mists of consumer memory. As a result, people tend to see services as overprice relative to hard goods. Hence, the problem faced by family doctors, pediatricians, dermatologists, and other doctors whose primary work is seeing patients. By contrast, surgeons and doctors performing diagnostic procedures are better compensated per minute of their time. Surgical procedures are a bit of a hybrid in that something like successful cataract removal is a one-time event with long-lasting, positive consequences. Prescription drugs have elements of both manufacturing (although research and development costs may be high and harder to recoup than found for consumer goods) and ongoing personal service because one needs in many cases to continue purchasing and using the pharmaceutical product for years on end.

Ultimately, these are empirical questions. My point is that there is nothing to suggest that Medicare has resolved them less well than a more tight-fisted insurer. Although government programs might be more vulnerable to inflationary pressures stemming from politics and public opinion, private insurers are similarly vulnerable to excessive deference to the profit motive. If I were having cataract surgery (or most any other medical procedure), I would rather have the decisionmakers err on the side of pricing and policies that will make skill service and good treatment outcomes more likely. This of course may make for higher per service costs under a government single-payer program. But administrative cost savings may make up the difference and certainly appear to do so in Canada and Europe. To the extent that they do not fully do so, this may simply be the price paid to medical providers by a wealthy nation for high quality health care that produces collateral economic and social benefits.

In other areas of medical costs, it is similarly hard to see private insurers doing particularly better than government insurers regarding cost control. Consider the matter of hospital costs. Again, personal experience drives my thinking along with aggregate data. In January 2006, I was stricken with a severe infection, high (105 degrees Fahrenheit) fever, substantial body aches and pain and a tennis-ball sized cyst on my liver. After this was detected in an MRI, I was instructed by my doctor to get into the nearest hospital for further care, which consisted primarily of intravenous antibiotics. The IV antibiotics worked wonders. Within 36 hours, my fever had abated and I was considered out of danger, although still feeling weak, horrible, achy, etc. The infectious disease specialist prescribed a six-week regime of continued IV drugs followed by weeks of orally taken antibiotics. Eventually (but probably not fast enough), I began self-administering my IV antibiotics at home with “picc” line in my arm.

The draining of the liver cyst presented more complex and confrontational issues. At the hospital, it was quickly agreed that the cyst should be drained. The staff radiologist felt it was too dangerous to do this without surgery, which the general surgeon was only too happy to perform, although this would have necessitated a long (6-8 week) recovery period from the invasive surgery alone. On the good advice of doctor friends, we located another radiologist who reviewed the CT scan and X-ray film and concluded that the cyst could be safely drained with the less invasive insertion of a needle, preferably as an outpatient proceeding but possibly requiring post-op hospitalization depending on the results. It took days of wrangling to get discharged from the first hospital. Drainage at the second hospital (where the second radiologist had privileges) went well but the

condition of the withdrawn cyst material prompted the doctor to require hospitalization because of fears of internal bleeding.

All this happened on the Friday before the 2006 Martin Luther King holiday weekend, which meant that getting physician follow-up was difficult. Finally, by the ensuing Wednesday, I was discharged. The situation was made more difficult because my former primary care physician did not visit patients in the hospital. Instead, the overall supervision of my care fell to the “hospitalists” or general care internists that contracted with the hospital. During both my hospital stays (10 days total), the hospitalists spent a total of about 15 minutes with me (or which they billed more than \$750, a rate that most would agree is unconscionably high for doctors with this level of skill and comparatively little overhead as compared to “regular” doctors maintaining an office). During those 15 minutes, they (four different doctors for the hospitalist group were involved) misstated my record on several occasions. Fortunately, I was conscious and could correct them. They also were slow to discharge me, first for the drainage of the cyst and second for home IV care.

During our cumulative 15 minutes together, they asked probing questions such as whether I raised goats in the back yard and whether that might be a source of the infection. I successfully suppressed the urge to remind the doctor in question (a non-native graduated from a non-U.S. medical school) that we were in Las Vegas, not Waziristan. Subsequently, I switched to a primary care physician who would (a) visit me in the hospital to make sure my care was appropriate and (b) did not have an economic incentive with his hospital client to keep me in the hospital longer than necessary (a goal that Wayne, Smith and King would presumably support).

Finally, some weeks after this experience, I received communication from the hospital and other care providers (although, perhaps unsurprisingly, the hospitalists lagged, not billing for the services until more than a year later, without having submitted the bill to my insurer, even though I had provided them insurance information upon admission to the hospital). My insurer (or rather the claims administrator that contracts with the State of Nevada’s self-insured plan) was reasonable.⁸⁶

86. Our biggest imbroglio was that it did not want to pay for the second hospitalization because it had not been pre-cleared. In response to the insurer’s original denial, I explained that the original treatment plan was to perform cyst drainage on an out-patient basis and forgo hospitalization but that, reacting to what he saw during the procedure, the radiologist, a senior, well-respected doctor in town, required hospitalization as a precaution out of concern over possible post-drainage internal bleeding. (I suspect he

When the final bills rolled in, they were substantial, although having survived, I was more than happy to pay my 20 percent co-pay and move on with life (which, in cliché-like fashion, I appreciated all the more after this series of misadventures in the medical system). What continues to bug me, however, is that there seemed to be lots of fat in this system that could have been much better controlled by non-avaricious medical professionals and a more enlightened private insurer/claims management company.

First, there is the absolute cost of hospitalization. It averaged about \$2,000 a day. I realize there is a lot of overhead required for a hospital, but this seems just too much for ordinary, brand-x rooms and nursing care. As in many cities, nursing staffs are stretched thin. There were typically only four nurses on the floor and, judging from my regular sojourns around the floor, they had many patients in far worse shape than me. They also spent a considerable amount of their time in record-keeping, even to the neglect of patients buzzing for assistance. I was ambulatory within a day or so of the first admission, another sign that it might have been appropriate to have both hospital stays shortened. (But it was a major boon to be able to walk to the juice cooler with my IV tower in tow because waiting for the nurses resembled waiting for Godot.)

Two thousand dollars a day for basic hospitalization? In most cities, one can get a suite at the Ritz for about a third of that amount. And, presumably, one could purchase a considerable amount of private nursing care and rented medical equipment for the other half. Part of the problem, of course, is that patients like me are not in much of a position to shop among hospitals, compare prices, and make price-conscious decisions. Residents of rural areas have even less opportunity for comparison shopping--another problem with the consumer-driven mythology. Even for elective surgery, one finds relatively little difference in cost when shopping around (which I did some years before in connection with a hip replacement), assuming one can get a hospital or doctor's business office to provide straight answers to questions about costs (reticence I suspect comes from difficulty in talking about their stated rates and discounted rates paid by insurers). Under these circumstances, one might hope that insurers could drive a harder bargain with hospitals. In addition, one must again ask the comparative question: Are the rates paid by private insurers committed to quality care significantly less than those paid by government programs?

would not have kept me in the hospital as long as the hospitalists and the hospital, who had an economic interest in my continued stay, did). So informed, my insurer agreed the hospitalization was apt.

If not, much of the efficiency-based argument for continuing to cling to a private insurance model loses its steam.

If nothing else, private insurers (at least judging from my experience) have not done much to control adverse financial incentives of medical providers. In fact, one might argue to the contrary. Once the hospitals discovered that I had good insurance, they wanted to keep me as long as possible. The hospitalist physicians, when they could be found at all, were distinctly unhelpful in trying to speed my release even after it became clear that further hospitalization was not required. The hospitalists also wanted more and repetitive tests. (I was CT-scanned twice in three days and had to figuratively stomp my feet in refusing to have a third before getting out of the first hospital after a five-day stay). The hospitalists and a general surgeon practicing at the first hospital were only too eager to subject me to major abdominal surgery without even exploring the possibility that perhaps my liver cyst could be drained by needle after all. In the end, I had a feeling akin to a tourist on a desert island with one vendor, who wanted to exploit this market advantage for all it was worth until the ship to shore arrived.

My question: why do insurers, who supposedly want to control runaway costs, not do more to forbid these adverse incentives (more on that below regarding problematic professionalism) or police them more aggressively? In my experience, the only real check on price gouging through churning of services and an excessively extended stay was the professionalism of some of medical personnel involved⁸⁷ and my own nagging (aided by my family), which avoided more expensive surgery and finally got me released from the two hospitals.

Of course, this latter factor suggests that market cheerleaders are on to something in wanting to empower consumers. They simply fail to appreciate the practical limitations on even educated consumers and seem to forget that the uninsured patient of modest means have almost no leverage over anything relating to medicine. Perhaps most important, they

87. For example, the invasive radiologist, the infectious disease specialist, the hospital nursing staff, and the insurance administrator's case manager were all supportive of an earlier discharge and transitioning to less expensive outpatient home care as soon as possible but were delayed by the slowness or mixed motives of the hospitalists. In addition, my efforts to obtain better, safer, less expensive treatment were aided by doctor friends in the local medical community, even though they were not my treating physicians. An impoverished, working class, uninsured, or less educated person would be less likely to know a helpful doctor through social connections.

fail to realize the practical limits on my degree of empowerment as a consumer, at least in this manner with some concrete potential for reducing medical costs, is no less if I am covered under Medicare or a government single-payer program rather than a private insurer.

During my time in hospital purgatory, there were other examples of the insurer being relatively lax in cost control. Consider prescription drugs that I regularly take. Once admitted to the hospital, I was forbidden to bring my regular “stash” of pharmaceuticals, which includes cholesterol, blood pressure, and anti-gout medicine. Instead, the hospital insisted on administering these prescriptions to me from its stock – at a cost of about \$20 per pill (as compared to the regular cost of about a dollar per dose). I realize that there can be problems with patients self-medicating. But this hardly seems to justify a system in which hospitals (who probably get the drugs for less than I would “on the outside”) are permitted to impose a 2000 percent markup in price – willingly paid by the insurer that is supposed to be such a stringent guardian of costs.

When I was finally liberated from the hospitals, I was visited by a wonderfully competent, straight-to-the-point home care nurse who instructed me in self-administration of the antibiotics and then peacefully left without looking for any other ways to run up costs (although she was helpfully available by phone for questions and her company replenished supplies as necessary). Notwithstanding that this part of my treatment was sensibly streamlined, the costs for the IV equipment and drugs was significant, approximately \$500 per week. Although this is a lot less than the \$2,000 per day at the hospital (plus itemized charges, including the IV drugs received at the hospital), it still seems high. I realize that drug manufacturers need to recoup the cost of research and development as well as continuing overhead and distribution costs. But I was receiving Zocyn, a common antibiotic that has been in use for years. One might reasonably expect a truly efficient private medical and insurance system to be able to get the costs of such at-home drug care down to something like \$200 per week.

All in all, then, my medical experiences of early 2006 strongly suggested that the medical community and private insurance does a quite imperfect job in both treating patients and containing costs. During the course of 10 days in two hospitals and three months of treatment (including visits to other specialists recommended in light of possible wear-and-tear on my liver and kidneys from all this), I was treated by a couple physicians I came to see as highly competent, with a fairly wide range of empathy and willingness to explain things to the patient. Overall, my condition was treated appropriately and successfully, but not very efficiently. However,

some of the medical professionals cut a less positive figure. The hospitalist physicians were worse than worthless from my patient's perspective. Ironically, this business model of medicine is touted in many quarters as a more efficient way to deliver services. The primary family physician can remain in her suburban office park and see more patients more often while the hospitalist can efficiently attend to the needs of the hospitalized patients. My experience suggests this theory is seriously flawed.⁸⁸

To the extent that the private insurer involved attempted to control costs, it was with fairly crude all-or-nothing measures rather than targeted attempts to prevent churning or inflated prices. For example, my insurer initially balked at my second hospitalization before accepting that it was medically necessary.⁸⁹ But it readily paid for \$20 pills, multiple expensive tests, fairly expensive IV drugs, and hospital rooms at Helmsley Palace prices. Could, Medicare and Medicaid really be worse in this regard, as Hyman argues? If not, there is no reason to fear a national single payer system on efficiency grounds. The question is not how government programs compare with perfection. The question is how government programs compare to their private insurer counterparts.

More to the point of this Symposium: many aspects of medical treatment and coverage today are intrinsically removed from the consumer. In my case, I perhaps could have shopped better for a hospital with lower rates, a more daring or accomplished resident radiologist, or better hospitalist physicians. But I was running a 105 degree fever at the time and my primary care physician was counseling immediate hospitalization and treatment of a rather large liver cyst. Under those circumstances, comparison shopping and shrewd consumerism is unlikely.

Of course, not all medical situations are acute or time-sensitive. But even garden variety routine medical care is reasonably esoteric and has some temporal imperative that prevents consumer choice. If a five-year old has a fever and joint aches, this is probably just the flu. But what parent other than Joan Crawford⁹⁰ will delay treatment while calling doctors for a

88. I have since switched to a primary physician who will visit hospitalized patients and serve as a check on the quality and expense of care provided by the hospitals and their associated vendors. What continues to astound me is the popularity of a professional and business model so rife with conflicts of interest and incentives for more bureaucratic, expensive, lower quality care.

89. *See supra* note 86.

90. The parental shortcomings of Crawford, a popular actress in the 1940s and 1950s, were extensively chronicled in her daughter's memoir. *See* CHRISTINA CRAWFORD, *MOMMIE DEAREST* (William Morrow 1978).

price quote? In addition, there are practical problems that likely limit aggressive consumer cherry picking. What doctor will accept episodic patients who come to her for flu symptoms, go elsewhere for earache, and try a third doctor for annual checkups because of lower prices? Even if doctors had no problem being commodified in this manner, there would likely be a rise in both the logistical costs of coordinating care and the substantive quality of care. My experience in the hospital suggested that doctors seeing patients episodically are overly dependent on patient charts, which may be inaccurate or misread.

For elective surgery, comparison shopping is equally or more difficult. Patients can get information, but it is not easy or cost free (all of this takes time, usually from working parents who lose productivity from this process as well as the need to nurse a sick family member or themselves back to health after medical care). Costs will be roughly the same, since they are driven more by the status quo of government and employer corporate sovereignty more than any kind of market for services. Even if HSAs and other consumer-driven initiatives catch on, this will remain the case. In the real world, away from the drawing boards of the CATO institute and similar market-utopian think tanks, consumers are not in much of a position to improve health care or medical coverage.

III. PROBLEMATIC PROFESSIONALISM

Veneration of the private sector (Smith) also supports the traditional prestige of physicians. In a less well-known segment of the *Wealth of Nations*, Smith argued that professionals entrusted with important social functions, such as doctors (and lawyers, of course) should be well-compensated so that they had adequate incentive to provide thorough and competent care.⁹¹ In addition, although Smith did not specifically make this point, professionals under economic pressure can too often behave in distinctly unprofessional or sub-professional ways. The current system has managed to put such pressure on medical providers, particularly doctors, but at the same time has not provided universal care or adequate supervision of professional error.

Doctors are perhaps no longer placed on a pedestal or idolized or iconographic in the manner of the 1970s television series *Marcus Welby*. But they enjoy at least the ordinary prestige and deference accorded successful businesspersons (a legacy of Smith and Wayne) and in addition

91. See SMITH, *supra* note 6, at 111.

continued to be venerated for their assistance to patients in time of need. Other professionals (e.g., lawyers, accountants, architects, engineers) can only dream of enjoying the prestige and public good will held by doctors. As a result, the public is resistant to any medical coverage solution that even appears to reduce patient access to doctors of choice or to restrict the physician's professional discretion.

The problem with this aspect of modern medical insurance mythology is the public does not realize the degree to which doctor discretion and professionalism has already been severely compromised by the private sector and overall economic factors. Although the worst excesses from the era of HMO hegemony (e.g., "drive-by" maternity delivery) have been curbed, private insurers still have a great deal to say about the manner in which most doctors practice medicine.

In addition, even where an insurer is not directly choreographing the physician's treatment of a patient, other incentives of the current structure give rise to a situation in which we now have what I term "problematic professionalism." Although most doctors continue to perform acceptably well under adverse circumstances, medical care remains sub-optimal in spite of its costs due to twisted incentive structures.

Although the health care quilt is a mixture of public and private, for-profit insurers and their agents (e.g., claims administrators) have a central role in determining the quantity and quality of care received. Employers, particularly large employers, of course, have some leverage as purchasers of group insurance in that insurers will want to accommodate them for business reasons, particularly if the employer is willing to pay a sufficiently higher premium in return for desired coverage in a group policy. Employers thus play a key role to the extent they negotiate with insurers over the parameters of coverage.

But insurers appear to be the real 800-hundred pound gorillas of this process in that they design the basic menu of standardized medical insurance options, shape the parameters of negotiation, and largely have the final say over the contours of coverage.⁹² To a large degree in the U.S. the private insurance industry sets the parameters of compensation, treatment with as much practical force as any government (although Medicare as the largest insurer is also important). Although really large employers may

92. Once again, I differ with Hyman, who contends that Medicare is the "real" 800-pound gorilla in the health care jungle. See Hyman, *supra* note 63, at 1166 ("Medicare is the 800 pound gorilla of American health policy."). But see Hunter, *supra* note 75 (employers and insurers in tandem are figurative king of health care beast).

self-fund their insurance program by collecting funds that in theory will be adequate for the number of predicted claims, they also typically delegate policy and claims administration to an MGA or TPA that effectively operates as an insurer. Employers also typically purchase stop-loss insurance from a private carrier as well in order to spread the risk assumed by self-funding.

When the metaphorical dust settles, the insurance industry in effect operates as a private administrative agency regulating medical insurance coverage and delivery of medical services. Doctors can avoid this governance by insurance only if they are willing to forgo accepting patients' insurance or membership in an insurer HMO or network of preferred providers. And once participating in a PPO or HMO, the doctor must do it the insurer's way in order to remain in good standing and in order for services to the patient to be covered. The law to some extent gives insurers a further leg up by exempting them from antitrust law (subject to some limitations) per the McCarran-Ferguson Act⁹³ while doctors remain subject to antitrust law and are forbidden from concerted action in restraint of trade.

Doctors are now more than ever acting as small (or in the case of some large practice groups medium) sized businessmen, placing greater emphasis on cost control, customer volume, marketing, and reduction of costs in delivering services.⁹⁴ This can adversely affect the quality of care simply

93. See 15 U.S.C. § 1011 (2000).

94. For clarification: I am not discussing medical practice law and reform, which is beyond the scope of this article and most likely asserts only a modest direct impact on overall health costs, notwithstanding claims of cost-escalating defensive medicine and undue transaction costs spend on frivolous claims. See, e.g., Martha Raffaele, *Study: Malpractice Crisis had Little Effect on Pa. Doctor Supply*, INS. J., April 27, 2007, available at www.insurancejournal.com/news/east/2007/04/27/79016.htm; Jennifer Robison, *The doctor is out – for good: Some LV physicians can't afford to stay in medicine*, LAS VEGA REV. J., Mar. 25, 2007; Alicia Change, *Study: Four Out of 10 Medical Malpractice Cases are Groundless*, INS. J., May 11, 2006, available at www.insurancejournal.com/news/national/2006/05/11/68248.htm; *Study Says Wrong-Site Surgery Is Very Rare and Preventable*, INS. J., April 17, 2006, available at www.insurancejournal.com/news/national/2006/04/17/67367.htm. See also Silver & Hyman, *supra* note 61; Atul Gawande, *The Checklist*, NEW YORKER, Dec. 10, 2007, 86 (noting degree to which relatively simple intensive care protocols can effectively improve patient odds of survival but medical community slowness in adopting such protocols: “If a new drug were as effective at saving lives as Peter Pronovost’s checklist, there would be a nationwide marketing campaign urging doctors to use it.”) (italics in original); Keith Mattheessen, *Cutting Doctors’ Hours May Not Reduce Medical Errors, Studies Find*, INS. J., Sept. 6, 2007, available at www.insurancejournal.com/news/national/2007/09/06/83233.htm; George J. Annas, *The*

because of the undue pressure to see many patients as fast as possible in a typical business day in order to obtain sufficient revenues to earn desired income.⁹⁵

patient's right to safety, TRIAL, Oct. 2006, 38 (Hospitals have been slow to adopt measures that would prevent medical errors that injure patients.”).

However, the rancor occasioned by this issue and the degree it has driven a wedge between doctors, lawyers, and policymakers to the benefit of insurers undoubtedly helps to explain some of the dysfunctional policymaking in the area. See, e.g., Joe Mullin, *Nevada's Med-Mal Changes Help Doctors, Hinder Lawsuits*, INS. J., Feb. 9, 2007, available at www.insurancejournal.com/news/west/2007/02/09/76860.htm; Tress Balda, *Physician 'I'm sorry' bills continues to spread, Nine more states debate laws banning apology from use in litigation*, NAT'L L.J., April 30, 2007; Joelle Babula, *Medical Malpractice Insurance Crisis: Lawyers slam doctors with ad*, LAS VEGAS REV. J., July 16, 2002.

95. See JEROME GROOPMAN, HOW DOCTORS THINK 97 (2007) (describing financial and insurance incentives pushing physicians in direction of spending inadequate time with patients learning of their symptoms and case history); Uwe E. Reinhardt, *Economists' Model*, *supra* note 3; Peter Salgo, *The Doctor Will See You for Exactly Seven Minutes*, Peter Salgo, *The Doctor Will See You for Exactly Seven Minutes*, N.Y. TIMES, Mar. 22, 2006.

According to Salgo, a professor at Columbia University's College of Physicians and Surgeons, the new assembly line approach to seeing patients is closely linked to pressure from insurers, business consultants, and particularly HMOs, to which he attributes the formal requirements that doctors have no more than a seven-minute “encounter” with patients rather than a more flexible, open-ended interview that is likely to reveal more about the patient's condition.

This apparently kept shareholders happy. But it reduced the doctor-patient relationship to a financial concept in a business school term paper.

Doctors know you cannot provide compassion in seven-minute aliquots. But we have felt powerless to change things. The medical establishment has, many of us feel, simply rolled over and gone along to get along. It has sacrificed patients' best interests on the altar of financial return.

See Salgo, *supra*. Accord, Reinhardt, *Economist's Model*, *supra* note 3, at 463 (“group medical practices may tie the distribution of income to their members closely to each physician's ‘productivity’ and then unabashedly define productivity in terms of neither clinical outcomes nor patients' satisfaction, but strictly in terms of the gross revenue the physician brought into the clinic.”) (footnote omitted); Carl Elliott, *The Drug Pushers*, ATLANTIC MONTHLY, April 2006, 82 (“As American turns its health-care system over to the market, pharmaceutical reps are wielding more and more influence – and the line between them and doctors is beginning to blur”)(italics in original); Vanessa Fuhrmans, *Doctors Assail UnitedHealth's Threat of Fines: Sanctions would be imposed on physicians sending patients to out-of-network labs for tests*, WALL ST. J., April 10, 2007; Theresa Agovino, *Doctors Suspect Insurers' Rankings Measure Cost, Not Quality*, INS. J., Feb. 9, 2007, available at www.insurancejournal.com/news/national/2007/02/09/76830.htm; David

According to one widely taught business model, a physician who sees patients as part of her practice (as contrasted to a medical group providing only procedures) should spend no more than seven minutes with each patient. As Jerome Groopman has powerfully demonstrated, truncated time with patients contributes significantly to diagnostic error, especially if the patient's problems are atypical or complex. Without taking sufficient time to learn about the patient's malady, the doctor has an insufficient data base for applying her exercise of professional judgment, even if one assumes that some subset of seven minutes gives the doctor sufficient time to reflect adequately and reach a considered personal opinion.⁹⁶

Armstrong, *Critical Dose: Aspirin Dispute Is Fueled by Funds of Industrial Rivals; A Cheap Remedy for Clotting Used by Millions of Patients is Undermined by Research; Bayer's Friends Fight Back* WALL ST. J., April 24, 2006. But see Vanessa Fuhrmans, *Insurers Stop Paying For Care Linked to Errors*, WALL ST. J., Jan. 15, 2008; Vanessa Fuhrmans, *An Insurer Tries A New Strategy: Listen to Patients*, WALL ST. J., April 11, 2006.

However, to some extent, Salgo's proposed realistic solution to the problem of assembly line medicine involves a reasonable dose of the consumer-driven, market competition efficiency championed by Hyman. See *id.* ("solution to the problem" is "in the hands of our patients" who should "adopt a business mind-set when shopping for health care" and refuse to patronize brusque, patient-unfriendly physicians).

The problem, of course, is that it is increasingly hard to find these types of Marcus Welby-style doctors with room to take on additional patients. The seven-minute, assembly line doctor increasingly dominates the provider landscape and will continue to do so until the medical insurance and payment system provides better incentives for better quality care, including spending adequate time with patients.

This sort of medical consumerism is perfectly consistent with my preferences as outlined in this article. What separates Hyman and me to a large degree is that Hyman seems to me to convey the impression that insured patients are morally hazardous louts who over-consume medical care without acting as a check on cost or quality while I contend that natural patient desires for good care and experiences with the physician will allow some consumer policing of medicine – if the patients have the ability to pay. Without it, patients either skip care altogether, go to the cheapest doctor or the one with the most lenient collection agency, or rely on inefficient emergency room care for what should be office visits. See Bobinski, *supra* note 13, noting that Canadians on whole are much more likely to get concededly necessary medical care than Americans); Edit., *Emergency Room Delays*, N.Y. TIMES, Jan. 19, 2008 (attributing much of delay to demands placed by uninsured patients).

96. See GROOPMAN, *supra* note 95, at 268. The problem is hardly confined to private insurance providers. See, e.g., Alex Berenson, *Cancer Drug Representatives Spelled Out the Way to Profit*, N.Y. TIMES, June 12, 2007; Dan Stockman, *State service's Medicaid bills squeeze doctors*, FT. WAYNE JOUR.-GAZETTE, Sept. 10, 2006 (describing doctor's receipt of \$260,000 bill from government because "his pool of Medicaid patients costs too much money"). In the "haste makes waste" department, see also Shirley S. Wang, *Institute Cites Medication Errors, Suggests Changes to Cut Injuries*, WALL ST. J., July 21, 2006.

The cost-reduction programs for actual delivery of medical care and the higher office overhead (it takes more office staff to process required paperwork and haggle with insurers) prompted by insurers pushes against traditional professional excellence and tends to undermine the quality of medical care. In a sense, the insurance industry and government programs like Medicare, Medicaid, and the VA are no different. The question then becomes which type of entity will provide a better brand of coverage and medical care regulation when measured along the multiple dimensions of quality of care, amount of care, and cost.

Assessment of the quality-of-care dimension strongly suggests that private insurers, driven by profit motive as well as legitimate cost concerns, has to a large degree made medicine less of a profession and more of an assembly-line style business. The product dispensed is health care, but the mass produced health care of a medical Wal-Mart more than Marcus Welby.

On one level, this may be a positive development for a large category of consumers with routine medical problems that require only basic solutions. The Marcus Welby method (which included house calls) made for heart-warming (if occasionally corny) television but it wasn't very efficient. Some cost-benefit sharpening of service delivery under the traditional model is a positive development. On another level, however, the assembly line commodification and economy of scale in much current medical practice is undesirable in that it weakens the accuracy and depth of diagnosis. It can have particularly serious adverse consequences where medical problems are less typical or readily apparent and require greater professional involvement by the doctor.

Even for not particularly esoteric patient problems, the quality of medical care in this brave new world of medicine-as-a-business seems suspect. As recounted above in my simple brush with infection, IV antibiotics, and cyst drainage, the economic pressure placed on the medical care system by the current medical coverage system appears to produce suboptimal results, even if one credits the system with some significant restraint on costs. In my relatively unremarkable case, the supposedly wonderful system of private sector medical care and insurance produced primary physicians who don't go to hospitals or otherwise follow through with patient care and disengaged, ill-informed, hospitalists who provided no continuity of care but who appeared to be protecting the economic self-interest of hospitals at the expense of the patient. It also produced long waits and needlessly protracted hospitalization; excessive testing to "churn" my medical insurance portfolio to the benefit of hospitals and

providers; and exorbitant requests for compensation by doctors with limited diagnostic skill as well as inadequate motivation.⁹⁷

In general, much of modern medical care appears organized around the needs of insurers and medical providers rather than the patient. In addition to long waits, there are the “banker’s hours” of many physicians and practices as well as poor response to patients unfortunate enough to be stricken on evenings and weekends. Outside of the walls of a hospital, medical service providers appear fragmented and scattered almost as if intentionally attempting to test the patience of patients. In few medical practices can the patient be seen by the doctor and take common required lab tests that are part of shared medical records. The economics of the current system militate against it. As a result, patients requiring relatively simple things such as blood work, urine samples, x-rays, a CT scan, an MRI, or more intrusive scoping, can almost never get this done under the same roof (and certainly not on the same day or even a reasonably compressed time frame.

The net result is to require patients, most of who must miss work for medical care, to spent substantial hours crisscrossing metropolitan (or worse yet, larger rural) areas for hours or days on end in order to get a basic diagnosis, which then requires the patient to again relocate and queue in line for any procedures required to attack a medical problem.⁹⁸ Add to this substantial repetitive paperwork and at least some jousting with medical insurers, all against a backdrop of legitimate quality concerns, and there is more than a little worth criticizing in the status quo.⁹⁹

97. See *supra* notes 84-88.

98. See Hyman & Silver, *supra* note 61, at 959 (labeling situation “deplorable”). See also REGINA E. HERZLINGER, MARKET-DRIVEN HEALTH CARE: WHO WINS, WHO LOSES IN THE TRANSFORMATION OF AMERICA’S LARGEST SERVICE INDUSTRY 20-33, 250-51 (1997). The inconvenience of obtaining care of course pales in comparison to the problems and lost productivity that occurs when people are uninsured or lack adequate coverage. See generally Melissa B. Jacoby, *The Debtor-Patient Revisited*, 51 ST. LOUIS L.J. 307 (2007) (collecting data regarding lost productivity and value resulting from illness, injury, and medical treatment).

99. There also appears generally to be inadequate regulation of physicians. It appears, for example, that a disturbingly large number of doctors relocate their practices to new states simply to stay a step ahead of regulators in their former state of licensing. Some doctors are essentially on the lam from one state to another because of past problems in the prior state. For years, state medical boards have embarrassed themselves by failing to stop this sort of opportunistic pulling up of stakes and failed to required adequate disclosure of a doctor’s past problems. In one relatively recent and notorious case, a doctor with a checkered past who had relocated to Colorado committed egregious malpractice and seriously injured a boy. In outraged response, the state legislature enacted a law requiring

The economics of the current system appears to have undermined or even imperiled professionalism by encouraging an assembly-line like commodification of medicine and medical procedures. For receipt of diagnostic testing, lab work, and corrective procedures, including surgery, the problems appear primarily to be the inefficiency of delay and questions of competence by the service providers (who may puncture an organ, amputate the wrong appendage, etc.). For delivery of physician consultation, the effect is arguably more pernicious in that it robs diagnosticians of a precious tool – information – because primary care physicians, internists and other specialists often are unwilling or unable to listen effectively long enough due to the pressure of their business models and income goals.¹⁰⁰

Ironically, the financial pressure on doctors and their perceived need to ramp up the quantity of care delivered to make up for reduced insurer payments was arguably supported by the inventor of the invisible hand. Smith wanted professionals to be adequately paid and to have decent working conditions that would permit the professional to acquire necessary skill and breathing space for good judgment focused on the instant patient or client. He saw this as a necessary price to pay to obtain adequate professional services.¹⁰¹ But misapplication of Smith's primary faith in markets, coupled with the perhaps pathological ways in which the U.S. has deviated from a market model without replacing it with a comprehensive government model, has produced a status quo Smith would have abhorred: medical professionals who so scurry to earn what they consider an adequate income that they devote insufficient time to many patients, thereby truncating the information they receive, rushing to judgment that is often erroneous. As a result, diagnostic error is much higher than it should be. The correct diagnosis may not come until the patient has endured considerable pain and inconvenience at substantial cost and, in some cases, may not come at all or only after the patient's demise.

disclosure of such past events to prospective and current patients. Good doctors should embrace this type of regulation because it would be both good marketing and diminish the business of problematic doctors. It appears that only 17 percent of physicians ever are sued for malpractice and that a relatively small group of doctors create the bulk medical malpractice claims. As the saying goes, five percent of the people create 90 percent of the problems. But if the regulatory system does not adequately intervene, these five percent can wreak havoc for years or even decades.

100. See GROOPMAN, *supra* note 95, at 226-231.

101. See SMITH, *Wealth of Nations*, *supra* note 6, at 111.

Alternatively, it would seem much better to operate a system that was not so dependent on squeezing doctor income that it produced adverse collateral impact. One would expect a rational health care system to make it sufficiently attractive for a high quality treating physician to be sufficiently compensated for each interaction with a patient to spend adequate time with the patient.

IV. THE LIMITS OF CONSUMERISM AS A HEALTH CARE POLICY AND THE INEXORABLE CASE FOR COMPREHENSIVE PUBLIC MEDICAL INSURANCE

By now, it is obvious that more of my sympathies lie with the social justice and professionalism paradigms more than market and consumer choice models. Consequently, my sympathies lie more with Jost and Mariner, even though I am concerned that even their informative writings use what I have come to regard as the subtle but misleading nomenclature of personal responsibility and actuarial fairness. Notwithstanding these quibbles, Jost's piece persuasively highlights a major problem with HSAs and the larger consumer-driven movement. Even if it works for many, the primary beneficiaries are the largely healthy and wealthy, who hardly need the tax subsidy/shelter provided by HSAs. Beyond this, the consumer-driven health movement works against the communitarian norm and makes a universally effective medical coverage program harder to obtain. Mariner, in addition, to also noting the limitations of the consumer-driven health care initiative, presents the important insight that even something as seemingly uncontroversial as "wellness" programs can contribute to the undesirable erosion of community solidarity and social justice in medical care and coverage.

Hyman, although as usual raising many excellent points regarding the operation of government programs, remains too enamored of the market as a cure-all. This is too unrealistically sanguine a view, even for a Smithite, in light of the muddled, path-dependent history of American health policy. Establishment of true market hegemony is both practically feasible and undesirable in light of the core necessity of medical care, even for the comparatively impoverished, unwise, and irresponsible. Playing John Wayne to the more Martin Luther King-like postures of Jost and Mariner, Hyman also continues to give short shrift to the professionalism wing of Adam Smith's writing in that Hyman, although deferring to medical expertise over consumer preference on some matters (e.g., drive-by deliveries), often paints a picture of medical providers as greedy opportunists who would have been at home in the Enron boardroom. My

own view toward providers, particularly physicians, is more charitable, although Hyman's warnings in this regard cannot be totally ignored.¹⁰²

Ultimately, however, Hyman fails to persuade because his proposed solution to health care issues favors an impractical return to the pre-World War II yesteryear of the allegedly pure market-based medical care that supposedly once existed, accompanied by a presumed shrewd consumer participation in the market which will, according to Hyman, lower medical costs and enable patients to receive affordable medical care most pertinent to their needs. One might as readily believe that the tooth fairy will be coming to everyone's neighborhood soon.

First, it is too late to turn back the clock. Better to look forward rather than back and move from oligarchic medical insurance to true universal government-funded care.¹⁰³ Second, Hyman presumes an infallibly

102. Nor can it be ignored that much of Hyman's scholarship urges increased quality-enhancement efforts directed toward improving the performance of medical professionals. See, e.g., Hyman & Silver, *supra* note 61 at 958-59. In this quest, he sees a more effective role for consumer than I think is realistic while I support more stringent government efforts in this regard that will not be diluted by the economic incentives of private medical insurers.

103. This increasingly seems to be the position of many commentators. See, e.g., KRUGMAN, *supra* note 18, at 237-43 (proposing that Medicare be expanded to cover entire population); Peter D. Jacobson & Rebecca L. Braun, *Let 1000 Flowers Wilt: The Futility of State-Level Health Care Reform*, 55 KAN. L. REV. 1173 (2007); Maxwell J. Mehlman, "Medicover": A Proposal for National Health Insurance, 17 HEALTH MATRIX 1 (2007) (essentially suggesting expansion of Medicare, "[t]he most efficient administrative system for health insurance" based on October 2006 conference of health law experts); Artur Davis, *The Health Care We Owe Each Other: Universal Care as the 21st Century Social Compact*, 37 CUMB. L. REV. 425 (2006); John A. Nyman, *The Efficiency of Equity*, 37 CUMB. L. REV. 461 (2006); David U. Himmelstein & Steffie Woolhandler, *A National Health Program for the United States: A Physician's Proposal*, 320 NEW ENG. J. MED. 102 (1989) (proposing comprehensive national health care system); Annette Fuentes, *What's wrong with nationalized health care?*, USA TODAY, Sept. 19, 2007, available at <http://blogs.usatoday.com/oped/2007/09/what-wrong-wit.html> (supporting single-payer system); Milt Freudenheim, *Mayo Clinic Proposing A Universal Health Plan*, N.Y. TIMES, Sept. 15, 2007, C4, col. 4 ("But Mayo, in a proposal hammered out over 18 months by a panel of more than 400 health policy experts, is not advocating a government-run single-payer system. Instead, it suggested that private insurance companies be required to offer standard plans with many options, like the Federal Employees Health Benefit Plan available to government workers. Applicants for this insurance could not be turned down ... Lower-income people would get government help on a sliding scale." Ironically, Mayo Clinic co-founder Charles Mayo, then president of the AMA, had during the early 20th Century warned doctors to be wary of universal health insurance out of fear it would not only reduce physician incomes but undermine professional judgment and the doctor-patient relationship. See Cynthia Crossen, *Before WWI Began, Universal Health Care Seemed a Sure Thing*, WALL ST. J., April 30, 2007); Robert H. Frank, *A Health Care Plan So Simple, Even Stephen Colbert Couldn't Simplify It*, N.Y. TIMES, Feb. 15, 2007, C3, col. 1 (noting that "American

shrewd, disciplined consumer that never was and never will be, at least where medical and insurance purchases are concerned.¹⁰⁴ Third, as discussed above, Hyman's perspective, however wonderful it may sound in theory, fails to square with the practical realities of consumer ignorance, bounded rationality, heuristic error, reduced choice, lack of time for investigation, and general lack of meaningful ability to comparison shop for medical insurance coverage. In addition to the practical limitations on lay patients, the dominance of group medical plans alone dramatically distorts whatever chance might otherwise exist to tame medical costs and excessive use of services through empowered consumerism.

Realistic assessment of the lay citizenry should appreciate that people are on average normally not sufficiently rational, informed, or disciplined to be able make the type of consistently intelligent medical treatment decisions upon which the consumer-driven model depends if it is to be anything other than a government-subsidized tax break for the rich. Perhaps more important, nearly half of medical care already is subject to government funding and substantial regulation. A move toward a more market based, consumer-driven system would at best produce a hybrid that continues the inefficiencies of the status quo without much countervailing efficiency advantage and a redistributive trend toward the already well-off.

All this leads me to the inexorable conclusion that the optimal practical means to serve both community solidarity and true consumer choice is to expand Medicare and make it the mandatory medical insurance coverage for all Americans. This will, according to Hyman, bring cackles of delight in Hades as another American jumps on his posited road to hell paved with

costs are so high in part because the reliance on private insurance multiplies administrative expenses, currently about 31 percent of total outlays ... Most health economists agree that government-financed reimbursement is the only practical way to control these expenses, many of them stemming from insurers' efforts to identify and avoid unhealthy people. Canada's single-payer health system, which covers everyone, spends less than 17 percent on administrative expenses ... A move to a single-payer plan would save more than enough to compensate insurance companies for lost profits."); Bannister, *November is Coming*, *supra* note 1, at 27 (proposing a "[n]ew nonprofit insurance company ... [that] would provide basic health coverage for all. The nonprofit company might be run by elected citizens that would use open hearings to design plans and set premiums. One important safeguard against fiscal irresponsibility would be to prohibit the nonprofit from issuing long-term debt.")

104. Hyman's infallibly shrewd consumer must also be independently wealthy, retired, or otherwise have considerable time on his or her hands. Even if consumers possessed the tools to function in the market Nirvana posited by Hyman and scholars of similar bent, they would need more time for researching, making, assessing, and recalibrating their medical and insurance purchases than one can realistically assume is possessed by normal working people.

good intentions¹⁰⁵ by giving even more power to the Medicare juggernaut. I disagree, in part for reasons stemming from Hyman's own critique of Medicare, which he describes as a "Ponzi" scheme dependent on the attraction of new participants (a/k/a "marks" in Hyman's view) to finance the benefits of those who entered the Ponzi period at an earlier juncture.

Hyman is correct to point out that Medicare in its current form is too dependent on the young and healthy subsidizing older persons more demanding of (and in need of) medical care. As his devilish alter ego put it:

As you [Mephistopheles] correctly perceived many years ago, allowing everyone into Medicare would immediately bankrupt the program because the cross-subsidies that sustain Medicare are only achievable if there are sufficient marks *outside* the program to pay the necessary funds *into* the program. Program beneficiaries understand this point perfectly well. The demise of the [proposed 1993] Clinton plan was inevitable once it became clear that the plan would "take" from the elderly and "give" to the uninsured. We are far better off delaying the day of reckoning by a few years and allowing the gluttony of Medicare beneficiaries and the passage of time to increase the number of unsustainable commitments . . .

¹⁰⁶

This portion of Hyman's critique resonates, but does so in favor of making the move toward expanded Medicare sooner rather than later. To be sure, moving from a system designed to protect the elderly, and which as to some extent becomes afflicted with excessive interest group politics,¹⁰⁷ to one covering a larger, more diverse population with differing

105. Although considerably less extreme, Hyman in a sense is an intellectual heir of Friedrich Hayek, a libertarian who embraced individualism so strongly that he and his followers not only inveighed against the very real evils of communism and other forms of totalitarianism but also opposed even the sort of "soft socialism" that can provide the infrastructure necessary for civilized progress. *See, e.g.*, FRIEDRICH HAYEK, *THE ROAD TO SERFDOM* (1944). This also arguably makes Hyman heir to the considerably less intellectual John Wayne legacy.

106. *See* Hyman, *Mephistopheles*, *supra* note 63, 60 WASH. & LEE L. REV. at 1185-86 (emphasis in original; footnotes omitted).

107. As Hyman correctly points out, the adverse reaction of so-called "greedy geezers" (my and the media's term, not Hyman's) to the Medicare Catastrophic Coverage Act of 1988, which merely required Medicare beneficiaries to pay some of the cost of

incidence of medical needs will require some recalibration of benefits offered, prices paid, and funds collected (through tax, premiums, co-pays, and deductibles). But the experience of other nations strongly suggests that this can be effectively done in a manner that will eventually result in overall improvement of care at lower cost.

“[C]ritics of the single-payer plan have long railed against the specter of socialized medicine, suggesting that it means being treated by government functionaries” the “people who have experienced single-payer coverage firsthand seem unconcerned.”¹⁰⁸ As Cornell economist Robert Frank relates: “When one of my sons needed surgery for a broken arm during a sabbatical in Paris, for example, the medical system we encountered was just as professional as the American one and far less bureaucratic.”¹⁰⁹ My own experience with my son’s attack of bronchitis in Germany was similar. Seeing a doctor and filling the required prescription was faster, easier, and cheaper than had the same adverse medical event occurred in the United States – and my son was of course not even part of the German citizenry for whose benefit the plan was designed.¹¹⁰ At some

expanded coverage, and the political cowardice of Congress in repealing the act in the face of these tantrums, illustrates a problem with having government in the insurance business. *See supra* note 62. But there is no iron law that Medicare must be under-funded or poorly administered. More to the point: the occasional electoral pathologies of Medicare seem to me no worse than the chronic problems besetting system using private insurance. *See, e.g., supra* notes 4, 13, 18, *supra* (discussing high relative cost of U.S. medical care system); Mary Crossley, *Discrimination Against the Unhealthy in Health Insurance*, 54 KAN. L. REV. 73, 152 (2005) (“[P]eople with health problems increasingly are forced to shoulder the load of their own medical costs. The trend toward consumerism in health coverage shifts not simply costs, but also insurance risk, to individual insureds, and the results may be particularly dire for people in poor health.”); Nan D. Hunter, *Managed Process, Due Care: Structures of Accountability in Health Care*, 6 YALE J. HEALTH, POL’Y, L. & ETHICS 93, 145 (2006) (discussing problems associated with current system’s private adjudicative mechanisms for determination of necessity of care); George A. Nation III, *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured*, 94 KY. L.J. 101, 112 (2005) (noting degree to which current system warps pricing, resulting in posted retail price inflicted upon uninsured as contrasted to discounted price charged to insured patients).

108. *See* Frank, *supra* note 103, at C3, col. 1.

109. *Id.* at col. 5 “And [as Frank emphasizes for the slow to grasp] in France, which spends half as much on health care as the United States and has more doctors and hospital beds per capita, everyone is covered.” *Id.*

110. I realize that Germany has a system someone different than the arguably “purer” government single payer systems of France and Canada in that private insurance plays more of a role in Germany. But for purposes of this comment, I do not believe it unfair to lump Germany with what I call “single-payer” countries (because of national government commitment to and administration of medical insurance), to whom they are far closer

point, all the ideology and theorizing in the world must yield to the hard empirical facts suggesting that medical care in Western Europe and Canada appears to be both cheaper and superior on the whole than that of the United States.¹¹¹

Rather than attempting to demonize (in Hyman's case, quite literally) government insurance plans as spendthrift bureaucracies, we would be better off appreciating them as aspects of national infrastructure akin to roads, police and fire protection, and national defense.¹¹² A comprehensive medical care program for all (which realistically can only be achieved through the government-run, single-payer approach), like these other

regarding health care policy. See Jost, *Is Health Insurance a Bad Idea? The Consumer-Driven Perspective*, 14.2 CON. INS. L.J. 377 (2008); RICHARD KNOX, GERMANY'S HEALTH SYSTEM, ONE NATION, UNITED WITH HEALTH CARE FOR ALL (Faulkner and Gray 1993). Regarding non-U.S. health care systems, see generally ANTONIA MAIONI, PARTING AT THE CROSSROADS: THE EMERGENCE OF HEALTH INSURANCE IN THE UNITED STATES AND CANADA (Princeton University Press 1998);); CHRIS HAM (ED.), HEALTH CARE REFORM: LEARNING FROM INTERNATIONAL EXPERIENCE (Open University Press 1997) (discussing UK, Sweden, Netherlands and Germany as well as U.S.); FRANCIS D. POWELL & ALBERT F. WESSEN (EDS.), HEALTH CARE SYSTEMS IN TRANSITION: AN INTERNATIONAL PERSPECTIVE (1993) (providing a general overview with particular focus on German, Canadian, Swedish and British systems). But see William P. Gunnar, *The Fundamental Law That Shapes the United States Health Care System: Is Universal Health Care Realistic Within the Established Paradigm*, 15 ANNALS OF HEALTH L. 151, 156 (2006) (concluding that the answer is "no").

111. See *supra* notes 4, 13, 18, *supra*; Jacobi, *supra* note 4, at 535-36; Manfred Huber & Eva Orosz, *Health Expenditures Trends in OECD Countries, 1990-2001*, 25 HEALTH CARE FIN. REV. 1 (2003).

112. Of course, the current American government treatment of these infrastructure issues is not particularly encouraging. See Free Hiatt, *She Brakes for Ideology*, WASH. POST, Jan. 23, 2008, A15, available at <http://www.washingtonpost.com/wp-dyn/content/article/2008/01/20/AR2008012002275.html> ("[T]raffic congestion already is costing the U.S. economy as much as \$200 billion a year.").

My primary point, however, is that there is no doubt that inadequate infrastructure imposes costs on society. We do not enjoy net savings simply because we spend less (and do less) regarding roads, bridges, policemen, fireman, soldiers – or health insurance.

Further, many of the current government's failures concerning the transportation infrastructure stem not from institutional incompetence but from ideology-based resistance that recently has trumped sound policy analysis. See Hiatt, *supra* ([According to the Bush Administration, the "main reason you are sitting in traffic . . . is not that the purchasing power of Highway Trust Fund revenue has been dwindling for the past decade, not that population and freight traffic have been soaring with no government response – but that you are not being asked to pay enough to use the road you are on.") Hiatt also notes that the Bush Administration rejected a bipartisan federal commission's "comprehensive, balanced plan for the next 50 years, calling for maintenance *and* construction, road *and* rail, public *and* private roads." *Id.* (emphasis in original).

infrastructure programs, provides a platform for greater national productivity¹¹³ as well as social justice and a chance for medical professionals to practice their craft under a set of incentives more supportive of quality care.¹¹⁴ Only some small increment of faux individualism is lost.¹¹⁵

American attitudes toward health care and medical insurance continue to be unduly dominated by accidents of history and the mythological power of the nation's archetypes. The rugged individualism embodied in John Wayne, and the market efficiency associated with Adam Smith are today's dominant archetypes. Although each embodies characteristics that are desirable in general (who can, as a general proposition, be against individualism, personal responsibility, ambition, free markets and greater

113. See, e.g., Jennifer Robison, *Staffs May Shrink: Plurality of companies say they'll thin ranks as costs for health insurance rise*, LAS VEGAS REV.-J., Jan. 21, 2008, available at <http://www.lvrj.com/business/13942712.html>. For example, employers freed of the burden of being the nation's front line source of medical coverage would also be freed of the need to make personnel and payment decisions based on consideration of the cost of group medical care.

114. See Furrow, *supra* note 14, at 417 (“[T]he moral argument of social solidarity with our fellows, so eloquently put by Timothy Jost in his comparative work on European systems, pulls in tandem with the conservative argument that more health care is better for the economy.”) (citing TIMOTHY S. JOST, *DISSENTLEMENT?: THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE* (Oxford University Press 2003)).

115. In *Wealth of Nations*, Adam Smith made a similar defense of public works spending as a useful investment to assist the market economy in reaching its full potential. See SMITH, *supra* note 6, at 473-85. Thus, there was an “infrastructure” Smith as well as a professionalism Smith and a market Smith. Although the pro-market, “invisible hand” Smith is most prominent in his writing, the American adaptation of Smith has tended to completely ignore Smith's support of professionalism and infrastructure.

Some see this and the overwhelming American aversion to self-consciously adopting a government single-payer system as a product of interest group conspiracy. See, e.g., MICHAEL TOWNES WATSON, *AMERICA'S TUNNEL VISION: HOW INSURANCE COMPANIES' PROPAGANDA IS CORRUPTING MEDICINE & LAW* 276 (Horatio Press 2006). Although the lobbying and public relations campaigns of insurers, drug companies, medical providers, and other interest groups have undoubtedly all contributed to fostering the “market-uber-alles” ethos of the U.S., my own view is that it is largely the organic product of the historical evolution of American self-identity.

America celebrates markets, personal wealth, and rugged individualism like no other country in the world. By contrast, Canadian culture gives proportionately greater celebration to collective national enterprise, such as the building of the Trans-Canadian railroad. In Canada, the thousands of workers get credit. In the U.S., the CEO of the railroad company would likely be the hero of the story. This difference in national psyche goes a long way toward explaining the different national systems of medical care and insurance.

economic wealth?), slavish, blind, and inflexible devotion to these idealized concepts has produced an unwillingness to face basic operational and empirical facts about the optimal means for maximizing access to health care and medical coverage for the citizenry.¹¹⁶

Without doubt, a government-administered public insurance plan is the optimal route. Whatever theoretical uncertainty may exist in thought experiments or political debate is belied by the empirical evidence. Canada, Great Britain, France, Italy, Scandinavia and Germany all spent about half as much per capita on health care as the U.S. and have healthier, longer-lived populations. Of these countries, only Germany has anything looking in any way similar to the public-private partnerships urged by the most liberal of American politicians. The others are all government-run single payer systems of medical insurance. England actually runs the medical side as well as the insurance side and has what might accurately be termed socialized medicine in which the doctors work for the government. Most important, Medicare has operated successfully as a single-payer form of public insurance for 40 years. Its imperfections can be improved upon and its reach extended.

116. See Stone, *supra* note 53, at 486-87. Deborah Stone's assessment of the excesses of this ethos is even more condemning:

The consumer choice approach to social policy represents a cynical turn in American public philosophy. . . . More often than not, "consumer choice" and "consumer direction" are glittery wrappings in which employers, insurers, and politicians package benefit reductions, program contractions, and budget cuts.

Giving people a budget that is too small for their needs does not give them the experience of freedom. Instead, they experience every decision not as free choice but as a terrible trade-off.

* * *

Consumer choice theory is thus an ideology. It is a way of seeing the world, and particularly a way of interpreting social justice. It is a philosophy that minimizes communal obligations to citizens, maximizes individually responsibility for one's own well-being, and tolerates great inequalities in well-being as morally acceptable. It replaces a social commitment to meeting needs with commitment to meeting budgets. It uses the rhetoric of "freedom" and "autonomy" to justify the abdication of social responsibility and the failure to provide appropriate and compassionate care.

See Stone, *False Promise*, *supra* note 53, at 486-87. See also Stone, *Beyond Moral Hazard*, *supra* note 48.

The actual operation of health care and insurance in the real world demonstrates that the single payer system and close equivalents are simply more efficacious than the American status quo and so-called “consumer-driven” alternatives. It no longer makes sense to shy away from this approach simply because of the aura associated with Wayne and the market side of Smith’s persona. After too long a period of the dominance of these images, the time has come to reassert the professionalism side of Smith and, more important, the social justice and community solidarity values embodied in Martin Luther King’s legacy.

CONCLUSION

To be sure, a government can administer a medical coverage system badly. But it is equally true that a government-run system can be efficient, probably at least as efficient as the current insurer-dominated, employer-dominated system. Greater progress will be made when policymakers focus on the factors that make for effective government operation of insurance coverage and free themselves from the tyranny of legal fictions and mythology about the infallibility of markets, personal fault, consumer omniscience, medical provider behavior, and private insurer efficacy.

HEALTH INSURANCE: MARKET FAILURE OR GOVERNMENT FAILURE?

David A. Hyman¹

“A society that does things that are inefficient or perverse in their effects ought to be told so.”²

I. INTRODUCTION

Health insurance is once again on the policy agenda, and it is déjà vu all over again. There are the same troubling statistics -- 47 million Americans are uninsured, and 20 million Americans are “under-insured” (whatever that means).³ There are the same anecdotes about the tragic consequences of being uninsured. There are reports by government agencies, think tanks, and do-gooder organizations. There are the same policy entrepreneurs, pushing old wine in new (and not so new) bottles. There are the same appeals to social solidarity, self-interest, or both. The interest groups are back in force as well -- each seeking to protect and advance their own interests, while asserting their deep and abiding concern for the broader public interest.⁴ Reform proposals are being pushed by all the usual suspects, including local, state and federal legislators, and all of the presidential candidates.

The reform proposals vary in their specificity, but all (either implicitly or explicitly) identify the source of the problem as “market failure” – and promise new regulations and more taxes to “fix” the problem. This article follows a different approach, and makes the case that “government failure” should occupy center-stage in understanding how things came to look the way they do. Rather than market failure, it is our inefficient and perverse

1. Richard & Marie Corman Professor of Law and Professor of Medicine, University of Illinois.

2. GEORGE STIGLER, *Are Economists Good People?*, in MEMOIRS OF AN UNREGULATED ECONOMIST 6 (University of Chicago Press 2003) (1988).

3. U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2006 (2007). The claim that someone is underinsured is rhetorically appealing, but essentially meaningless, absent some shared understanding of “adequate” coverage. Efforts to define “adequate” coverage typically result in the determination that everyone should have “gold-plated” coverage. That is exactly what everyone would have if cost were no object. It isn’t.

4. Strictly speaking, they never left.

regulation of health insurance that should be the focus of our ire, and of regulatory reform.

Part II briefly outlines the existing market and regulatory framework for health insurance. Part III explains the sources of government failure in the market. Part IV outlines some possible approaches to addressing the problem of government failure. Part V concludes.

II. ESSENTIALS OF REGULATING THE HEALTH INSURANCE MARKET

Approximately 61 percent of the non-elderly population (totaling 260 million people) receives health coverage through an employer.⁵ 5 percent purchase individual coverage.⁶ 16 percent receives government-sponsored coverage, and 18 percent are uninsured.⁷

Why do so many Americans obtain health insurance through their employer – particularly when only 2% of the population had employment-based coverage in 1930?⁸ In an earlier article, I explained that this outcome was a historical accident, fueled by federal labor and tax policy:

The first dramatic increase in employment-based coverage came during World War II. Wage and price controls were instituted by the Office of Price Administration in an attempt to deal with inflation. Employer contributions to insurance and pension funds were not counted as wages, and were accordingly excluded from the wage controls. The freezing of cash wages forced employers to compete for scarce labor by enhancing their fringe benefit packages. Health insurance offered a straightforward way for employers to sweeten their compensation package in a manner that would be quite appealing to potential employees.

5. KAISER FAMILY FOUND, *The Uninsured: A Primer, Key Facts about Americans without Health Insurance*, KAISER FAMILY FOUND. 1 (Oct. 2007), available at <http://kff.org/uninsured/upload/7451-03.pdf>

6. *Id.*

7. *Id.* To be sure, how many uninsured there are depends greatly on how long one must be without insurance to qualify. If one focuses on the hard-core uninsured (those without coverage for a two year period), the number of uninsured is far smaller.

8. Robert B. Helms, *The Tax Treatment of Health Insurance: Early History and Evidence, 1940-1970*, in EMPOWERING HEALTH CARE CONSUMERS THROUGH TAX REFORM 1, 8 (Grace-Marie Arnett ed., 1999).

The second impetus for employment-based coverage was the federal tax code. In 1943, the Internal Revenue Service issued a ruling indicating that the amounts paid by employers for insurance for employees did not constitute income to employees, even though employers could deduct these amounts as ordinary and necessary business expenses. Ten years later, the IRS withdrew this ruling, but Congress amended the Internal Revenue Code in 1954 to expressly exclude employment-based coverage from taxable income. In effect, this asymmetric tax treatment allows employers to purchase health insurance for their employees using employees' before-tax income, rather than forcing employees to purchase it themselves with after-tax income. The amount of the subsidy is a function of the marginal tax rate for any given taxpayer, but its size is larger for higher-income taxpayers because of the progressivity of federal taxation. In the aggregate, this subsidy is worth more than \$100 billion in foregone tax revenue per year, and is the second largest tax expenditure, after home mortgage interest. The result is a substantial financial incentive for employees to obtain coverage through their employer if at all possible.

Labor unions were another factor in the rise of employment-based coverage. During the late 1940s and 1950s, unions aggressively bargained for richer benefit packages, with health insurance at the top of their list. In industries in which unions were strong (e.g., manufacturing and public-sector employment), the result was that many subscribers obtained first-dollar insurance coverage and medical care at no out-of-pocket cost to themselves whatsoever. Employers with non-unionized workforces also offered rich benefits to discourage their employees from unionizing.⁹

9. David A. Hyman & Mark Hall, *Two Cheers For Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y, L. & ETHICS 23, 25-26 (2001-2002) (footnotes omitted).

The linkage between employment and health insurance has significant distributional consequences. Large and mid-size employers are more likely to offer coverage, and more likely to offer a choice of coverage than small employers.¹⁰ Employment-based coverage is much less likely to be offered to those who work in certain industries (e.g., agriculture, retail, and food service), and those working less than full-time.¹¹

The link between employment and health insurance also has substantial regulatory consequences. Pursuant to the McCarran-Ferguson Act, states have primary regulatory authority over insurance sold to state residents.¹² However, federal preemption of state regulation (with or without direct federal regulation) is always possible, as long as Congress expressly indicates its intention to affect the “business of insurance.”¹³ Thus, the Employee Retirement Income Security Act broadly preempts state regulation of employment based health insurance -- except to the extent the employer provides coverage by purchasing a state-regulated health insurance contract.¹⁴ Conversely, employment-based health insurance is not subject to state regulation if the employer self-funds the coverage it provides to its employees.¹⁵ Of those who obtain health insurance through their employer, 45 percent are funded by the employer purchasing a health insurance contract, and 55 percent are self-insured by the employer.¹⁶

In practical terms, this framework means that the 71 million Americans who obtain coverage individually or through an employer’s insured plan are subject to both state and federal regulation, while the 87 million Americans who obtain coverage through an employer’s self-funded plan are subject only to federal regulation.¹⁷

How have the federal and state governments exercised this regulatory authority? At the federal level, there has been relatively limited direct regulation of health insurance. When ERISA was enacted in 1974, it focused on pension plans, and imposed no substantive regulations on

10. *Employer Health Benefits: 2007 Annual Survey*, KAISER FAMILY FOUND. & HEALTH RES. & EDUC. TR. 4-5, 58 (2007) [hereinafter *2007 Annual Benefits Survey*], available at <http://kff.org/insurance/7672/upload/76723.pdf>.

11. *Id.* at 34.

12. 15 U.S.C. § 1012(a) (2000).

13. 15 U.S.C. § 1012(b) (2000).

14. Such coverage is called an “a ‘fully insured plan.’” *See 2007 Annual Benefits Survey*, *supra* note 10, at 146.

15. Such coverage is called a self-funded plan. *Id.*

16. *Id.* at 147.

17. *See id.* at 1. *See supra* note 16 and accompanying text.

employment-based health insurance.¹⁸ Over the intervening 34 years, there have been a few new substantive regulations, including requirements prohibiting “drive-through deliveries,”¹⁹ requiring parity in coverage of mental health treatment,²⁰ and imposing limits on the use of preexisting condition exclusions.²¹ Because ERISA preempts state law, but does not impose much in the way of substantive regulation, this framework means that self-funded employers have operated in a virtual regulatory vacuum. Self-funded employers are more likely to operate in multiple states, so this regulatory vacuum has meant such employers can implement uniform coverage arrangements without worrying about state-by-state regulatory variation. Stated differently, the current framework provides self-funded employers with virtually complete freedom to design and implement whatever health care coverage they desire – including spending as little or as much as they want.²²

At the state level, there has been a massive amount of regulation affecting every aspect of the relationship between insurers, providers, and patients. As Figure 1 demonstrates, there are three distinct relationships that can be regulated: the relationship between the insurer and the physician/provider (Type I regulation); the relationship between the physician/provider and the patient (Type II regulation), and the relationship between the patient and the insurer (Type III regulation).²³

18. See Hyman & Hall, *supra* note 9, at 29.

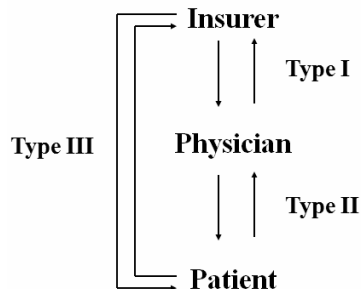
19. Newborns’ and Mothers’ Health Protection Act of 1996, 42 U.S.C. §300gg-4 (2000).

20. Mental Health Parity Act of 1996, 29 U.S.C. §1185a (2000 and Supp. 111 2004) and 42 U.S.C. §300gg-5 (2000 and Supp. 111 2004).

21. See 26 U.S.C. §9801 (2000 and Supp. 111 2004); 29 U.S.C. §1181 (2000 and Supp. 111 2004); 42 U.S.C. §300gg (2000).

22. See Amy B. Monahan, *Pay or Play Laws, ERISA Preemption, and Potential Lessons from Massachusetts*, 55 U. KAN. L. REV. 1203 (2007); Retail Industry Leaders Assn. v. Fiedler, 475 F.3d 180 (4th Cir. 2007).

23. There are also regulatory strategies that do not fit neatly into this model, such as solvency regulation and premium taxes. All states employ such strategies, and impose premium taxes as high as 3%. JEFF LEMIEUX, AHIP CTR FOR POLICY & RES., PERSPECTIVE: ADMINISTRATIVE COSTS OF PRIVATE HEALTH INSURANCE PLANS 1 (2005), available at http://www.ahipresearch.org/pdfs/Administrative_Costs_030705.pdf. Because of ERISA preemption, self-funded employers are not subject to such taxes.



Examples of Type I regulation include “any willing provider” legislation, restrictions on compensation mechanisms, and prohibitions on “gag clauses.” Type II regulation includes mandated disclosure of qualifications, results, and incentives to limit care. Type III regulation includes mandated coverage of certain benefits, such as alcohol treatment, and post-partum stays, and provisions affecting the circumstances and price at which insurance may be offered (including guaranteed issue and community rating).

States have adopted numerous Type I and Type III regulations, but relatively few Type II regulations.²⁴ The number of Type I and Type III regulations also appears to have grown dramatically over time.²⁵ The most common Type I regulations are any willing provider/freedom of choice legislation covering chiropractors (46 states), psychologists (44 states) and optometrists (43 states).²⁶ The most common Type III regulations are mandated coverage of newborns (50 states), alcoholism treatment (45 states) diabetic supplies (47 states), breast reconstruction after mastectomy (48 states), and mammograms (50 states).²⁷

Proponents of mandates sometimes suggest that they decrease costs. By and large, this argument is pure sophistry. Proponents are focusing on the fact that those receiving the mandated services suddenly face lower out-of-pocket costs, but this result is a mathematical consequence of spreading

24. See Victoria Craig Bunce et al., *Health Insurance Mandates in the States 2006*, COUNCIL FOR AFFORDABLE HEALTH INSURANCE (2006) [hereinafter CAHI], available at http://www.cahi.org/cahi_contents/resources/pdf/MandatePub2006.pdf.

25. Compare U.S. GEN. ACCOUNTING OFFICE, GAO/HEHS-96-161, *HEALTH INSURANCE REGULATION VARYING STATE REQUIREMENTS AFFECT COST OF INSURANCE* 9 (1996) (“On average, states have enacted laws mandating about 18 specific benefits), and CAHI, *supra* note 24, (identifying more than 1800 mandates, or 36 per state).

26. CAHI, *supra* note 24.

27. *Id.*

the costs for those receiving the mandated treatment across a larger population. This result is obviously not the same thing as lower costs overall.

To the extent private insurance is not already providing the mandated coverage, the mandate will increase costs – with the magnitude of the increase affected by a number of factors, including the elasticity of demand for the mandated services.²⁸ Estimates of these costs vary widely.²⁹

III. JUDGING THE REGULATORY FRAMEWORK

What is there to be said for (and against) this regulatory framework? There is broad agreement that some regulation of health insurance is appropriate – but once one moves beyond the core issues of solvency and externalities, there is considerable disagreement on what should be regulated and how to do so. In part, the disagreement is attributable to the use of different analytical frameworks. Those using a neo-classical economic framework are likely to focus on the problems of adverse selection, moral hazard, and the fact that health insurance contracts are

28. In theory, a mandate could lower overall costs if broader *ex ante* use of the mandated treatment resulted in lower costs *ex post*. For example, if better screening for and treatment of hypertension lowered hospitalization rates for heart attacks, mandated coverage might result in lower costs. But, if *ex ante* investment resulted in lower costs *ex post*, it is unclear why rational insurers would fail to make such investments, unless they did not expect to internalize the costs of the heart attacks – and voluntary contracts offer a way for insurers and insureds to handle such “churn.” The fact that insurance is purchased through intermediaries (usually employer human resources departments) also suggests that this problem is more theoretical than real.

29. CAHI, *supra* note 24 (“Based on our analysis presented in this paper, mandated benefits currently increase the cost of basic health coverage from a little less than 20% to more than 50%, depending on the state.”); Gail A. Jensen & Michael A. Morrissey, *Employer-Sponsored Health Insurance and Mandated Benefit Laws*, 77 MILBANK Q. 425, 444-445 (1999) (estimating cost of mandates ranging from 4% - 13%). See also *Assessing the Impact of Mandated Health Insurance Benefits on Cost and Coverage*, RUTGERS CENTER FOR ST. HEALTH POL’Y 5 (2007), available at <http://www.cshp.rutgers.edu/Downloads/7120.pdf>.

[I]t is clear that there is not a consistent and compelling body of evidence to support the notion that mandates have had a major impact on health insurance premiums, employer decisions to offer health insurance, and coverage. While several earlier studies showed greater impacts of mandates on cost and coverage, more recent studies using improved methods found only small impacts or, in some cases, no statistical associations of mandates with cost or coverage.

Id.

complex and incomplete.³⁰ This lens is likely to lead to regulations addressing opportunistic behavior by both the insurer and the insured.

Those using a behavioral economic framework are likely focus on the fact that human beings have better things to do with their time than read insurance contracts -- and even if they read them, they are likely to discount or ignore inefficient coverage terms.³¹ This lens is likely to lead to the willingness to mandate coverage of terms that individuals would supposedly want (and be willing to pay for) if they were perfectly rational.³² Those using this framework typically assume that regulators can identify inefficient and efficient coverage terms, and only impose the latter -- although they generally offer no evidence to support this assumption.³³

Those using a redistributionist framework are likely to focus on their desire to transfer resources from the more fortunate (healthy and wealthy) to the less fortunate (sick and poor).³⁴ This lens is likely to lead to coverage mandates that individuals would not be willing to pay for if they were perfectly rational -- which is, after all, the definition of redistribution.

30. See generally David A. Hyman, *Regulating Managed Care: What's Wrong with A Patient Bill of Rights*, 73 S.CAL L. REV. 221 (1999-2000).

31. See *Id.* at 234.

Life is short, and reading the fine print in one's insurance contract is not high on most peoples' list of favorite weekend activities - particularly when they do not perceive that their efforts will have any effect on the terms of the contract. Even if one is prepared to read the insurance contract, it does not follow that one will pay attention to the specific terms which, after the fact, turn out to be important. Against this backdrop, 'bounded rationality' constrains the operation of market forces which would normally ensure the optimal mix of quality and price.

Id.

32. Russell Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1 (1999-2000).

33. See DEPARTMENT OF JUSTICE & FEDERAL TRADE COMMISSION, IMPROVING HEALTH CARE: A DOSE OF COMPETITION 31-32 (2004) [hereinafter DOJ/FTC], available at http://www.usdoj.gov/atr/public/health_care/24694.pdf.

For mandates to improve the efficiency of the health insurance market, state and federal legislators must be able to identify services the insurance market is not currently covering for which consumers are willing to pay the marginal costs. This task is challenging under the best of circumstances -- and benefits are not mandated under the best of circumstances.

Id.

34. Hyman, *supra* note 30, at 247.

All three of these frameworks share an underlying assumption that regulation is driven by the public interest. A fourth framework (public choice) emphasizes that regulation often reflects rent-seeking behavior by special interests, and accordingly counsels for great skepticism regarding the merits of most such initiatives.

It would be nice to report that the entirety of the regulatory framework described above fits neatly into one of these four analytical approaches. As always, reality is messier than theory – particularly when one tries to apply oversimplified theories of regulation to the real-world oversight of a massive industry by more than a hundred potential regulators.³⁵ Indeed, it would be somewhat surprising if the regulatory framework for health insurance reflected a single animating theory, since regulation of the health care sector in general reflects the impact of multiple inconsistent normative frameworks.³⁶

Thus, individual mandates can result from any one of these regulatory frameworks, or the combination of more than one of these frameworks. Despite this heterogeneity, in-depth examination of individual mandates reveals an important commonality: provider lobbying figures in most of them – often aided by a small group of affected patients and/or relatives of patients.³⁷ These groups offer legislators pre-packaged salient anecdotes to support reforms that “fortuitously” result in insulating these providers from the operation of market forces (Type I regulations), and more and better coverage of the services these providers wish to deliver (Type III regulations). The costs of these “reforms” are widely shared (and generally off-budget), but the benefits are highly concentrated – precisely the circumstances under which collective action problems can be overcome.³⁸

35. 50 state insurance commissioners plus 50 state legislatures plus Congress equals more than 100 potential regulators.

36. Mark A. Hall, *The History and Future of Health Care Law: An Essentialist View*, 41 WAKE FOREST L. REV. 347, 354-356 (2006) (noting a plethora of competing organizing principles in the regulation of health care).

37. ALAIN C. ENTHOVEN & LAURA A. TOLLEN, TOWARD A 21ST CENTURY HEALTH SYSTEM: THE CONTRIBUTIONS AND PROMISE OF PREPAID GROUP PRACTICE 238 (2004) (“Often these mandates are legislative responses to the demands of narrow interest provider and consumer constituencies, such as disease specific advocacy groups or nurses associations, for instance.”); *DOJ/FTC*, *supra* note 33, at 24 (“providers of the mandated benefit are usually the most vigorous proponents of such legislation, making it more likely that the mandated benefit constitutes ‘provider protection’ and not ‘consumer protection.’”).

38. ENTHOVEN ET. AL., *supra* note 37 at 238.

Although these reforms are styled as “consumer protection,” they are, more often than not, “provider protection.”³⁹

If legislators were Platonic guardians, the problem would take care of itself. They aren’t, and it won’t. Legislators have neither the information nor the inclination to identify only cost-justified/efficient reforms. Indeed, saliency bias dramatically increases the probability that health insurance regulation will come to grief, diserving the interests of those the legislators purportedly intended to protect.⁴⁰

The problem is easy to state but hard to solve:

Legislators tend to identify “necessary reforms” on the basis of bad anecdotes and popular appeal. . . . Legislators also tend to discount the trade-offs and costs which result from their reforms. In a voluntary insurance market, cost-increasing consumer protections will predictably price some people out of the market-and it is hardly self-evident where the cost/quality/access equilibrium should be set, let alone whether there should be a single standard for all

39. See Alain C. Enthoven & Sara J. Singer, *Markets and Collective Action in Regulating Managed Care*, 16 HEALTH AFF. 26, 30 (1997) (“one should be sure that what is being proposed is consumer protection and not provider protection masquerading as consumer protection.”); Peter T. Kilborn, *Bills Regulating Managed Care Benefit Doctors*, N.Y. TIMES, Feb. 16, 1998, at A1 (“The quip going around is that this is physician protection, not consumer protection.”)

40. See Hyman, *supra* note 30, at 248:

Coverage and delivery issues that are salient to consumers will be handled without much difficulty through normal market mechanisms so long as consumers are actually willing to pay for the desired services. However, in order for an issue to attract legislative attention, it must be salient to consumers as well. If the issue is not salient to consumers, it will have little or no appeal to legislators, who must allocate their scarce political capital to bills that will be perceived by their constituents as beneficial. The result is that legislative initiatives promoting cost-justified contract terms will generally duplicate contract terms already prevalent in the coverage market. To the extent the legislation does not duplicate existing contract terms, it is exceedingly likely that the proposed contract terms will have already been rejected as non-cost-effective, either by the market as a whole, or, in a well-differentiated market, by some of the market participants and their customers. Such contract terms are embraced by the legislature for their symbolic value or as a political pay-off, and not because they provide a cost-justified benefit to consumers.

Id.

coverage. The drafting of consumer protections is also readily hijacked by entrenched providers, who have their own interests at heart. Finally, the emotional implications of these issues ensure that legislators will be reluctant to embrace the necessary trade-offs.⁴¹

Those wishing a concrete example of how this dynamic plays out in the real world should consider the fuss over “drive-through deliveries” – the practice of discharging women and newborns from the hospital less than forty-eight hours after a vaginal delivery and ninety-six hours after a Cesarean section.⁴² The issue was ideal from a legislative perspective: vulnerable mothers and babies exploited by faceless health plans, grieving witnesses complaining of specifically identifiable (and immensely sympathetic) victims, suited villains with MBAs, and CPAs overriding the decisions of selfless physicians in white coats, and a largely off-budget solution. In relatively short order, an overwhelming majority of the states and the federal government mandated more extensive coverage. Prohibiting drive-through deliveries was politically popular, but there is little or no evidence that extended post-partum stays provide any benefit – let alone a benefit worth the substantial associated cost.⁴³ Worse still, the mandate crowded out alternative arrangements that actually benefitted and were preferred by new mothers. With successes like this, who needs failure?

That said, why should anyone care about this particular dysfunctional corner of the regulatory state? Isn’t setting minimum standards what we rely on legislators and regulators to do – even if they opt for overly rich benefit packages some of the time? Unfortunately, such “minimum standards” can have substantial adverse consequences – with those consequences compounded by the regulatory monopoly that each state has pursuant to the McCarran-Ferguson Act.

These adverse consequences include:

41. *Id.* at 236.

42. David A. Hyman, *Drive-Through Deliveries: Is Consumer Protection Just What the Doctor Ordered?*, 78 N.C.L. REV. 5, 24 (1999) [hereinafter Hyman, *Just What the Doctor Ordered*]. See also David A. Hyman, Commentary, *What Lessons Should We Learn From Drive-Through Deliveries?*, 107 PEDIATRICS 406 (2001).

43. Hyman, *Just What the Doctor Ordered*, *supra* note 42, at 9.

1. Forcing individuals who can't afford more expensive coverage to do without insurance entirely – thus increasing the number of people who are uninsured;
2. Forcing those who can afford more expensive coverage to purchase it, even though they have better uses for the money;⁴⁴
3. Constraining competition on the financing and delivery of health care services;
4. Taking money from the poor and working class, and giving to the upper middle class, who provide (and disproportionately receive) the mandated services.⁴⁵

The basic problem is that health insurance is a bundled product sold into a diverse market, to people with varying intensity of preferences for coverage with different cost-quality-access trade-offs. Mandates are based on the assumption that there is one right answer to these trade-offs – but the reality is that all Americans do not want (and some can't afford) coverage which incorporates all the bells and whistles. For many consumers, regulation actually overrides their preferences, instead of protecting them, and does so at their expense. Stated differently, “people may die or suffer adverse outcomes if their insurance does not cover ‘everything,’ but they will also die or suffer adverse outcomes if they are unable to afford health insurance. . . setting an inefficiently high level of health care quality as the mandatory minimum ignores both the short-term consequences for price and access and the long-term consequences of increased price and decreased access on quality.”⁴⁶

44. Cf. David Hyman & Charles Silver, *And Such Small Portions: Limited Performance Agreements and the Cost/Quality/Access Trade-Off*, 11 GEO. J. LEGAL ETHICS 959, 978 (1998).

Clients who can afford the best do not necessarily want to pay for it. They may happily purchase limited legal services and put the money they save in the bank, the stock market, or whatever else strikes their fancy. A person wealthy enough to own a Rolls Royce can drive a Plymouth and keep the change—at least as long as the Rolls Royce dealers have not put the Plymouth dealers out of business.

Id.

45. See generally Barak D. Richman, *Insurance Expansions: Do They Hurt Those They Are Designed to Help?* 26 HEALTH AFF. 1345 (2007).

46. *Hearings on Health Services, Regulatory Costs, and the Uninsured Before the AEI-Brookings Joint Center for Regulatory Studies* (2004) [hereinafter *Hearings*] (statement of David A. Hyman), available at <http://www.aei-brookings.org/admin/authorpdfs/redirect-safely.php?fname=../pdffiles/phpUi.pdf>.

It is clear that the cost of health insurance is a major factor in why so many people are uninsured.⁴⁷ Given that reality, it is far from clear why we should accept a regulatory framework that offers people the choice between “nothing but the best and nothing.”⁴⁸

IV. TREATING THE PROBLEM: A DOSE OF TAX REFORM AND REGULATORY FEDERALISM

If one wanted to improve on the status quo, there are two obvious targets: the tax treatment of health insurance, and the elimination of state-specific monopolies on insurance regulation created by the McCarran-Ferguson Act and ERISA. Each of these targets is addressed in turn.

A. TAX SUBSIDY

As noted previously, individuals who obtain health insurance through their place of employment receive a sizeable tax subsidy. In its current form, the tax subsidy is the source of considerable horizontal and vertical inequity and allocative inefficiency.⁴⁹

47. David A. Hyman, *The Massachusetts Health Plan: The Good, the Bad, and the Ugly*, 55 KANSAS L. REV. 1103, 1113, n. 49 (2007); William M. Sage, David A. Hyman & Warren Greenberg, *Why Competition Law Matters to Health Care*, 22 HEALTH AFF. 31, 35 (Mar./Apr. 2003) (“When costs are high, people who cannot afford something find substitutes or do without. The higher the cost of health insurance, the more people are uninsured. The higher the cost of pharmaceuticals, the more people skip doses or do not fill their prescriptions.”). See also Posting of David Cutler to Blog for Our Future, *available at* <http://www.ourfuture.org/blog-entry/adviser-describes-obama-health-plan> (June 1, 2007, 4:07 EST).

Let's face it, the major reason that 45 million Americans don't have health care and many others are going without needed medical care is not that they don't want it, it's that they can't afford it. . . . No matter how much we tell Americans they should, or even have to, buy health insurance, the fact is that people will not get coverage unless it is affordable.

Id.

48. *Hearings*, *supra* note 47 (testimony of David A. Hyman) (“We should not place the poor and less fortunate in the position of choosing between ‘nothing but the best and nothing’ when it comes to health care coverage – but excessive regulation will do exactly that.”).

49. Clark C. Havighurst & Barak Richman, *Distributive Injustice(s) in American Health Care*, 69 LAW. & CONTEMP. PROBS. 7, 42 (2007); Hyman & Hall, *supra* note 9.

There is no shortage of proposals on the best way to fix the problem.⁵⁰ We should pick one and give it a try. My personal preference is to repeal I.R.C. §106, and see if we can make health care less expensive by making it more expensive.⁵¹ That said, “leveling up” is likely to prove more politically feasible than “leveling down,” and if that is the grease for fixing the some or all of the existing tax inequities, so be it – allocative inefficiencies notwithstanding. Fixing the tax subsidy may also help increase portability of coverage, by uncoupling it from a specific employer.

B. REGULATORY FEDERALISM

The framework for regulating health insurance is a mess. Identical coverage (from the perspective of covered employees) is regulated quite differently, depending on whether the plan is self-funded or insured. There are also state-specific regulatory monopolies, with little effective constraint other than employers and individual citizens exiting from the market entirely (by relocating) or virtually (by self-funding their coverage or no longer offering insurance if they are employers, or becoming uninsured if they are individuals).⁵² The unsavory combination of regulatory monopoly,

50. Reform options include:

[R]epealing the exclusion outright; continuing to exclude it from income, but capping its value and allowing it to erode over time; converting the exclusion to a tax credit; leaving the existing exclusion alone, but adding tax credits as a subsidy for the poor; making the exclusion more universal. . . . excluding all out-of-pocket spending on health care; and, so on.

David A. Hyman, *Getting the Haves to Come Out Behind: Fixing The Distributive Injustices of American Health Care*, 69 LAW CONTEMP. PROBS. 265, 274 (2007).

51. I.R.C. § 106 (1986) (“Gross income does not include contributions by the employer to accident or health plans for compensation (through insurance or otherwise) to his employees for personal injuries or sickness.”).

52. See Hyman, *supra* note 30, at 230, n. 23:

[A]ny significant regulatory mismatch provides an incentive to employee benefit plans to become self-funded, in order to avoid the costs associated with state-level regulation. Thus, the efforts of the states to regulate in this area have effectively backfired, since they have become increasingly aggressive at regulating a vanishing market-and their efforts increase the rate at which the market vanishes.

Id. But see Christina H. Park, *Prevalence of Employer Self-Insured Health Benefits: National and State Variation*, 57 MED CARE RES. REV. 340, 343 (2000) (finding no association between number of state mandates and percentage of employers who are self-funded).

off-budget costs, and the politics of mandating is also likely to result in mandate creep.

How should we address this unhealthy dynamic? A number of approaches have been floated, including direct federal regulation/chartering, deregulation, association health plans, exclusive state regulation, and cross-border sales of health insurance.⁵³ I suggest an alternative strategy that blends certain of these elements, while exploiting the benefits of jurisdictional competition.⁵⁴ The goal is to identify the “Delaware” of health insurance regulation.

There are different ways of creating jurisdictional competition in health insurance regulation.⁵⁵ The most comprehensive approach requires amendment of both McCarran-Ferguson and ERISA. Under this approach, insurance companies would pick the state they wished each of their insurance products to be regulated by (“home jurisdiction”). ERISA preemption would be constrained, and ERISA plans would be required to designate a home jurisdiction as well.⁵⁶ Individual states could only prohibit the sale of insurance policies to their state’s residents if the insurer had not designated a home jurisdiction. Premium taxes could only be collected by the home jurisdiction, but they would have to be shared 50:50 with the jurisdiction where the insured resides.

The result of this approach is the creation of a national market for health insurance coverage. States should compete for the premium taxes associated with the sale of insurance subject to their regulation – and the inclusion of ERISA plans ensures that a sizeable amount of new money is at stake. States would have to take a hard look at the aggregate cost of the mandates and premium taxes they impose, knowing that the wrong decision would result in the loss of a sizeable amount of revenue. States would also be constrained from adopting too lax a regulatory framework by the knowledge that their own residents will be subject to the same regime. The sharing of premium taxes allows states to maintain their traditional

53. See generally Amy Monahan, *Federalism, Federal Regulation, or Free Market? An Examination of Mandated Health Benefit Reform*, 2007 U. ILL. L. REV. 1361 (2007).

54. See *New State Ice Co. v. Lieberman*, 285 U.S. 262, 311 (1932) (“It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.”).

55. For a different model, see HEALTH CARE CHOICE ACT, H.R. 4460, 110th Cong. (2007).

56. Although this will make ERISA plans subject to state-level regulation, only one state will get to regulate them. Thus, the problem of inconsistent state regulatory regimes, which ERISA was designed to address, is not a problem.

consumer protection efforts to ensure that health insurers do not misbehave. Finally, the elimination of the ERISA regulatory vacuum will eliminate the pressure for Congress to directly regulate in this area.

If states do not want to wait for federal legislation, they can implement a similar regulatory result by entering into regional compacts. Each state can agree to allow the sale of any health insurance product that was acceptable to the other states, and share the associated premium taxes and enforcement responsibility. Paradoxically, the states whose residents would benefit the most from jurisdictional competition are the least likely to participate in such regional compacts. Yet, all it takes is two states to agree to begin the process of jurisdictional competition – and the results will tell us a lot about how much individuals and employers actually value state-level regulation of health insurance.

To be sure, broader markets for health insurance, whether structured on a national or regional basis, will make life more difficult for states that wish to regulate inefficiently or hide the costs associated with the use of regulation to redistribute resources. It is not obvious why more transparency on the consequences of health insurance regulation should count as a problem. Stated more bluntly, these effects are a “feature, not a bug.” If states want to regulate inefficiently, they are certainly entitled to do so – but they should bear the costs of their inefficiency. Similarly, states that want to engage in redistribution have no valid objection if jurisdictional competition forces them to squarely confront the costs of their largesse – particularly if, as is often the case, the redistribution results from rent-seeking.

V. CONCLUSION

One could come up with a system for regulating health insurance that is more perverse than the one we have, but it would take both effort and creativity. As Bill Simon, former Treasury Secretary once observed, our tax system should look like it was “designed on purpose based on a clear and consistent set of principles. . . .”⁵⁷ The same should apply to our regulation of health insurance and health insurers. Tax reform and regulatory federalism offer a strategy for rationalizing the system, by harnessing the self interest of all involved, and forcing legislators to face the costs of their decisions.

57. WILLIAM E. SIMON, BLUEPRINTS FOR BASIC TAX REFORM (1977), *available at* <http://www.ustreas.gov/offices/tax-policy/library/blueprints/forward.pdf>.

Regardless of the manner in which health insurance is regulated, private insurers will never behave like public insurers. If legislators actually want public insurance, they should enact it. If they can't do that, but they still think the mandated services are important, they should pay the market clearing price to have them delivered.⁵⁸ Of course, a world in which legislators/regulators have to "pay the piper" is a world in which legislators/regulators are suddenly much more cautious about imposing such burdens.⁵⁹

Playing legislative/regulatory whack-a-mole with individual coverage terms and individual insurers may be making providers, lobbyists and lawyers rich, but it isn't doing any favors for the consumers that are its intended beneficiaries. It is time to change the incentives for everyone involved.

Finally, although this article focuses on the regulation of health insurance, we should not ignore the similar pathologies that prevail in the regulation of health care delivery. That, however, is the subject for another day, another article, and another journal.

58. States could either pay insurers to include the desired services in their insurance plans, or they can pay providers for delivering them. Regardless of which approach is employed, state legislators would suddenly have to internalize the costs of the regulations they impose.

59. Hyman, *supra* note 30, at 249 ("Because the government provides coverage for a minority of those who are insured, the majority of the costs of 'reforms' considered by legislators are off-budget. Predictably enough, the result is more and costlier consumer protection than would be the case if the costs were on-budget.").

HEALTH INSURANCE RISK POOLING AND SOCIAL SOLIDARITY: A RESPONSE TO PROFESSOR DAVID HYMAN

Amy B. Monahan*

INTRODUCTION

Historically, Americans have valued social solidarity with respect to health care. That is, Americans have more or less supported the idea that health risks are appropriate to be shared within a community.¹ There is a tension, of course. Social solidarity with respect to health care means that the relatively healthy individuals will pay higher prices for health insurance in order to subsidize the health insurance of the relatively less healthy. Americans have generally supported this cross-subsidization. However, given ever-rising health insurance prices, there is now significant interest in lessening the extent to which health care risks are shared in our society.² As several contributors to this symposium have pointed out, instead of pooling our collective health risks we are creating ways in which individuals with low health risks can opt out of the risk pool or otherwise receive preferential treatment.³ This comment seeks to respond primarily to the regulatory federalism proposal put forward by Professor David Hyman, which I argue will unnecessarily harm certain risk-pooling functions of health insurance and therefore undermine social solidarity. I will begin first with a brief look at what risks are and are not currently pooled, before examining options for expanding health insurance risk pooling. I will then turn to Professor Hyman's proposal, analyzing regulatory federalism in light of its effect on risk pooling and social solidarity.

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1. See John V. Jacobi, *The Ends of Health Insurance*, 30 U.C. DAVIS L. REV. 311, 312 (1997).

2. See generally Amy B. Monahan, *Federalism, Federal Regulation, or Free Market? An Examination of Mandated Health Benefit Reform*, 2007 U. ILL. L. REV. 1361.

3. See Timothy Stoltzfus Jost, *Is Health Insurance a Bad Idea? The Consumer-Driven Perspective*, 14.2 CONN. INS. L.J. 377 (2008); Wendy K. Mariner, *Social Solidarity and Personal Responsibility in Health Reform*, 14.2 CONN. INS. L.J. 199 (2008) (describing the singling out of certain conditions for wellness programs, where the functional result is to "charge higher rates to individuals based on their personal health risks").

Before beginning, a brief note regarding terminology. A theme of this symposium is “social solidarity” with respect to health care. Social solidarity, generally speaking, refers to the connections between individuals within a society.⁴ “Risk pooling” on the other hand, is an economic term that refers to individuals joining together, through an insurance contract, to pool their collective risks.⁵ I use the terms “social solidarity” and “risk pooling” interchangeably in this comment because social solidarity with respect to health risk is expressed through the degree of risk pooling present in health insurance arrangements.⁶ As we increase the degree of risk pooling in health insurance arrangements we are increasing social solidarity with respect to medical risks.

I. WHAT RISKS ARE CURRENTLY POOLED?

The extent to which health risks are pooled varies based on the type of health insurance purchased. The first distinction is between (1) large group coverage and (2) individual and small group coverage. Large group coverage, offered by an employer, provides a high level of risk sharing.⁷ In such plans, all eligible employees typically pay identical premiums, regardless of age or health status.⁸ With respect to covered benefits, risks are both pooled and cross-subsidized.⁹ Of course, the extent of the risk pooling and cross-subsidization varies based on the size of the group. The larger the group, the more heterogeneous it is likely to be in terms of risk,

4. See A DICTIONARY OF SOCIOLOGY (John Scott and Gordon Marshall eds., 3d ed. 2005), *available at* <http://www.oxfordreference.com/views/ENTRY.html?subview=Main&entry=t88.e2165>.

5. See KENNETH S. ABRAHAM, DISTRIBUTING RISK 1-2 (1986).

6. See ENCYCLOPEDIA OF BIOETHICS 1122 (Michael J. Garland & Merwyn R. Greenlick eds., 3d ed. 2004) (“the insurance compact expresses an underlying solidarity among insurance pool subscribers”).

7. See ABRAHAM, *supra* note 5, at 1-2.

8. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibits an employer from varying premiums based on health status. See 29 U.S.C. §1182 (1996).

9. Generally, “risk pooling” refers to individuals within the same risk classification sharing the risk of unexpected losses. This is what takes place when health insurance premiums vary with health status. “Cross-subsidization” refers to the sharing of risk between individuals with different risk classification. For example, when young and old workers pay the same health insurance premium, the risk is cross-subsidized, with the young workers subsidizing the coverage of the older workers. See ABRAHAM, *supra* note 5, at 95 (describing cross-subsidization).

providing a greater amount of risk pooling and cross-subsidization.¹⁰ However, even in a large group plan with significant risk pooling and cross-subsidization, an important limitation results from the fact that only risks associated with the medical benefits covered by the plan are pooled and cross-subsidized.

Individuals and small groups are susceptible to two related risk-pooling problems. The individual market is particularly susceptible to adverse selection.¹¹ Adverse selection has been defined as “the annoying tendency of people to do what’s best for themselves.”¹² In the individual health insurance context, it occurs when a healthy individual forgoes coverage.¹³ If an individual is healthy and does not believe that she will incur medical costs in excess of health insurance premiums and related out-of-pocket costs, she is unlikely to enroll in health insurance.¹⁴ Conversely, if she has reason to believe that her medical expenses will exceed her health insurance premiums and the related out-of-pocket payments, she is likely to enroll in health insurance. As a result, individuals who purchase health insurance generally have greater-than-average risk.¹⁵ Premiums for individual health insurance therefore reflect the greater-than-average risk level of purchasers. Small groups are at a disadvantage in risk-pooling because they lack a diversified pool of purchasers.¹⁶ Small groups, while endogenous, do not have size sufficient to reflect community-wide risk

10. Employer groups also have the advantage that they are formed for non-insurance purposes. See David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL’Y, L. & ETHICS 23, 32 (2001).

11. *Id.* (stating that adverse selection is “particularly acute among the newly unemployed who were previously insured.”).

12. David Mark Tuomala, Panelist, Society of Actuaries, Consumerism and Consumer Choice-Implications for Health Plans, Dallas Spring Meeting 3 (May 30, 2001), in REC. SOC’Y ACTUARIES, Spring 2001, at 3.

13. See Alain C. Enthoven & Sara J. Singer, *Market-Based Reform: What to Regulate and by Whom*, HEALTH AFF., Spring 1995, at 109, available at <http://content.healthaffairs.org/cgi/reprint/14/1/105>.

14. *Id.* (explaining that “those who expect not to use their coverage are more likely to drop it.”). See also Hyman & Hall, *supra* note 10, at 32 (stating that “adverse selection discourages the purchase of insurance by some people who would otherwise have chosen to purchase coverage.”).

15. This is particularly true under community rating. See Hyman & Hall, *supra* note 10, at 32 (noting that “adverse selection is increased by laws, such as community rating, that require insurers to disregard certain risk factors.”).

16. Troyen A. Brennan, *An Ethical Perspective on Health Care Insurance Reform*, 19 AM. J.L. & MED. 37, 39-40 (1993).

levels and therefore are susceptible to poor experience rating and resulting high premiums.¹⁷

Both the individual and small group markets are further affected by the different types of state regulation. Some states have community rating laws, which require insurers to charge each covered individual the same premium, regardless of their health status.¹⁸ Other states allow insurers to adjust premiums based on risk, but constrain the amount of the adjustment using so-called rate bands.¹⁹ Often, states that have community rating requirements also have guaranteed issue laws, requiring insurance companies to offer insurance to every individual who applies for coverage.²⁰ Other states neither constrain the ability of insurers to adjust premiums based on risk nor require insurers to issue coverage to each applicant.²¹ While differing state regulation affects the degree to which risk is shared, in all states there appears to be a substantial degree of risk sharing among a state's privately insured population with respect to those benefits covered by the policy of insurance.²²

II. WHAT RISKS ARE NOT SHARED?

Health insurance protects against two primary types of risks: macro-level risk and micro-level risk. Macro-level risk is the risk associated with

17. See Enthoven & Singer, *supra* note 13 at 109 (noting that small employers are "too small to spread risks" and "achieve economies of scale in administration...").

18. See, e.g., N.Y. INS. LAW §3231 (McKinney 2008).

19. See, e.g., MO. ANN. STAT. §379.936 (West 2008).

20. See § 3231, *supra* note 18.

21. See Kaiser Fam. Found., Small Group Health Insurance Market Rate Restrictions, 2007, <http://www.statehealthfacts.org/comparetable.jsp?ind=351&cat=7> (last visited Mar. 3, 2008).

22. See Bradley Herring & Mark V. Pauly, *The Effect of State Community Rating Regulations on Premiums and Coverage in the Individual Health Insurance Market*, 20 (Nat'l Bureau of Econ. Res. Working Paper 12504, August 2006) (finding significant risk pooling even in states without risk rating limitations or guaranteed issue requirements, and noting the "apparent degree of pooling."). See also Enthoven & Singer, *supra* note 13 at 109 (stating that "the excess burden of cost from adverse selection in the individual market must be allocated to someone.").

medical expenses generally.²³ Micro-level risk is the risk associated with incurring losses associated with particular medical treatments or services.²⁴

Individuals with health insurance pool their macro-level risk, while those who lack health insurance of any kind retain the risk of loss associated with medical expenses. The only way to increase macro-level risk sharing is to increase the number of individuals with health insurance coverage.

While individuals with health insurance pool their macro-level risks, the particular scope of their insurance contracts determines which micro-level risks are pooled. For example, if an individual's health insurance policy does not cover cancer treatments, risk of loss associated with cancer treatments is retained at the individual level and not pooled. By enacting mandated benefit laws, federal and state governments regulate micro-level risk pooling by requiring coverage for certain benefits in all contracts of health insurance.²⁵ The risk of loss associated with any service or treatment not covered by a standard contract nor mandated by the state or federal government is retained at the individual level. In order to increase micro-level risk pooling, the scope of health insurance coverage would need to be broadened. The section below will briefly examine popular reform proposals, each of which focuses on increasing macro-level risk pooling.

III. WHAT CAN BE DONE TO BROADEN RISK POOLING?

As stated above, the only way to increase macro-level risk pooling is to increase the number of individuals with health insurance. Nearly 18% of the non-elderly population in the United States lacks health insurance.²⁶ Unfortunately, while we have many statistics on the uninsured population, relatively little is known about the factors that determine whether an

23. See, e.g., HENRY J. AARON & WILLIAM B. SCHWARTZ WITH MELISSA COX, CAN WE SAY NO? THE CHALLENGE OF RATIONING HEALTH CARE 95 (2005) (stating that health insurance efficiency is principally intended to protect against the "risk" of large and burdensome financial losses).

24. See Monahan, *supra* note 2, at 1365.

25. See *id.* at 1364-74 (describing state and federal regulation of the substance of health insurance contracts, as well as the related policy rationales).

26. Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2007 Current Population Survey*, EBRI ISSUE BRIEF, No. 310 at 4 (Washington, Employee Benefit Research Institute, Oct. 2007), available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_10a-20071.pdf.

individual purchases private health insurance.²⁷ We know that many cite prohibitive cost when explaining why they declined employer-offered coverage.²⁸ However, there is also significant evidence that demand for health insurance is not very price elastic.²⁹ In other words, in order to make significant improvement in rates of coverage, cost would have to decrease substantially.³⁰ Related to cost is also the issue of individual demand for health insurance. For example, young adults are significantly more likely to be uninsured than older adults, suggesting that demand may vary based on perceived risk.³¹

There is disagreement with respect to the most effective (and desirable) way to increase the number of individuals who are covered by health insurance. The primary reform proposals involve (1) changing the tax treatment of health insurance premiums, (2) requiring all individuals to purchase health insurance coverage, (3) requiring all employers to offer health insurance coverage to their workers, or (4) decreasing micro-level risk pooling in order to decrease costs.³²

27. M. Kate Bundorf et al., *Health Risk, Income, and the Purchase of Private Health Insurance* 1 (Nat'l Bureau of Econ. Res., Working Paper No. 11677, 2005) ("[S]urprisingly little is known about the factors that determine whether an individual obtains health insurance in private markets.").

28. See, e.g., Paul Fronstin, *Employment-Based Health Benefits: Access and Coverage, 1988-2005*, EBRI ISSUE BRIEF, NO. 303 at 8 (Washington, Employee Benefit Research Institute, Mar. 2007), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=973833.

29. See, e.g., Michael Chernew et al., *The Demand for Health Insurance Coverage by Low-Income Workers: Can Reduced Premiums Achieve Full Coverage?*, 32 HEALTH SERVICES RES. 453, 464 (1997) ("Although the overwhelming majority of individuals participate in their employer's plan, there appears to be a subset who do not, even at prices heavily distorted by the employer. For this group of workers, it is unlikely that a further subsidy would alter participation dramatically."). See also Jonathan Gruber & Ebonya Washington, *Subsidies to Employee Health Insurance Premiums and the Health Insurance Market* (Nat'l Bureau of Econ. Res., Working Paper No. 9567, 2008), available at <http://www.nber.org/papers/w9567>.

30. See generally Chernew, et al. *supra* note 29.

31. See Fronstin, *supra* note 26, at 15.

32. See, e.g., Friedman *infra* note 35 (arguing why tax preferences should be eliminated altogether); see also *infra* note 47 (proposing why all individuals should be required to purchase health insurance or be penalized); see also *infra* note 56 (mandating that employers offer health insurance to their employees); see also *infra* Part III.3 and *supra* Monahan note 2 (describing current legislative efforts to reduce the impact of state mandated benefit laws, the primary vehicle for enforcing micro-level risk pooling).

1. Tax Reform Options

Arguments in favor of tax reform are based both on fairness and affordability grounds. Currently, only self-employed individuals and those who receive coverage through their employer may pay health insurance premiums on a pre-tax basis.³³ This historical accident puts those who are not self-employed or who are not offered health insurance by their employer at a significant disadvantage when it comes to purchasing health insurance. These individuals must not only purchase insurance on the less-favorable individual market, but the price is not subsidized by the federal government.³⁴ Reformers propose remedying this disparity in different ways. Some propose that the tax preference should be eliminated entirely; there would be no preference for employer-provided insurance but the federal government would cease subsidizing the purchase of private health insurance for anyone.³⁵ Others argue that all individuals should be permitted to purchase health insurance on a pre-tax basis, thereby retaining the current tax preference for health insurance but making it universally available.³⁶ Concerned that even a universal ability to pay health insurance premiums on a pre-tax basis will not significantly increase insurance coverage levels, others argue in favor of various versions of a tax credit for the purchase of health insurance.³⁷

These proposals have markedly differing effects on their ability to increase levels of health insurance coverage and therefore to increase risk pooling. Eliminating the tax preference for insurance, while providing equitable treatment to all individuals, would not immediately decrease the cost of insurance. Rather, it would increase the cost of insurance for most

33. See I.R.C. §§106, 125, and 162(f)(1)(b).

34. See generally Amy B. Monahan, *The Promise and Peril of Ownership Society Health Care Policy*, 80 TUL. L. REV. 777 (2006) (explaining the effective federal subsidy available for employer-provided coverage).

35. See, e.g., Milton Friedman, *How To Cure Health Care*, 142 PUB. INT. 3 (2001), available at <http://www.thepublicinterest.com/archives/2001winter/article1.html>.

36. See Bradley W. Joondeph, *Tax Policy and Health Care Reform: Rethinking the Tax Treatment of Employer-Sponsored Health Insurance*, 1995 BYU L. REV. 1229, 1258 (1995) ("Congress should extend § 106's exclusion to *all* taxpayers regardless of the source through which they obtain coverage").

37. See, e.g., Press Release, The White House, Making Health Care More Affordable (Sept. 2, 2004), available at <http://www.whitehouse.gov/news/releases/2004/09/20040902.html>. (proposing that giving small business owners refundable tax credits for contributions they make to their employees' health savings accounts would reduce the rising cost of health care and promote affordable coverage options).

individuals in the short run. Nonetheless, proponents argue that it might very well increase coverage rates. Economists argue that, absent the current economic distortions associated with employer-provided health insurance, individuals would elect to purchase less comprehensive insurance coverage.³⁸ With the price no longer subsidized by the federal government they would choose plans with higher deductibles and cost sharing levels, less comprehensive coverage, or both.³⁹ When individuals bear a greater portion of their medical expenses they will tend to spend less. And as individuals curb their medical expenditures the costs of both medical care and health insurance will fall.⁴⁰ As insurance prices fall, more individuals will be able to afford coverage. If the model works according to theory, this proposal could broaden macro-level risk pooling.⁴¹

The proposal to make the tax preference universally available would potentially lower the cost of health insurance for those who are not self-employed or do not have access to employer-provided coverage. However, the value of the deduction from gross income varies based on the individual's marginal tax rate. For those in the highest marginal tax bracket, the discount would be significant.⁴² For those without federal income tax liability, the exclusion would have no effect on health insurance affordability.⁴³ Of course, those without access to employer-provided health insurance are more likely to be lower-income individuals.⁴⁴ So, while broadening the current tax preference for health insurance would eliminate the current disparate treatment for individuals who are not self-employed or who lack access to employer-provided coverage, it seems unlikely to greatly increase the number of insured individuals.

38. See Friedman, *supra* note 35, at 7.

39. See *id.* at 2 (arguing that people will be more conservative in how much they spend for health coverage once they have to pay for it out-of-pocket).

40. David Hyman sums this up neatly by explaining that we should "make health care less expensive by making it more expensive." David A. Hyman, *Health Insurance: Market Failure or Government Failure?*, 14 CONN. INS. L. J. (forthcoming 2008).

41. Of course, the evidence regarding the price-elasticity of the demand for health insurance suggests that the magnitude of the effect on coverage rates would not be great. See Chernew et al., *supra* note 29 at 453, 466.

42. An individual in the top marginal tax bracket would get a "discount" of 35% on the cost of health insurance by virtue of being able to deduct or exclude health insurance premiums from otherwise taxable income.

43. In 2002, 30% of all individuals who filed federal income tax returns had no federal income tax liability. Michael Parisi & Scott Hollenseck, *Individual Income Tax Returns, 2002*, 24 STAT. INCOME 8, 24 (2004).

44. See Fronstin, *supra* note 26, at 10, 13-14.

The final tax reform option is to provide some form of tax credits to help subsidize the purchase of health insurance. Tax credits have the advantage of reducing an individual's tax liability dollar-for-dollar and therefore not varying with the individual's marginal tax bracket. However, non-refundable tax credits would not create a purchase incentive for individuals without federal income tax liability.⁴⁵ Because low income individuals are more likely to be uninsured than higher income individuals, many proponents argue that credit refundability is essential to the success of a tax credit proposal.⁴⁶ A refundable tax credit program appears to hold the most promise for effectively increasing health insurance coverage rates, but is also the most expensive tax reform option.

2. Purchase Mandates

Leaving aside the potential for tax reform, another popular reform option is to require all individuals to purchase health insurance and to impose a monetary penalty on those who do not.⁴⁷ This appears to be a promising method to address what we consider to be sub-optimal demand for health insurance.⁴⁸ This reform is particularly appealing if it will cause low-risk individuals—who might otherwise rationally decide to forgo health insurance—to opt-in to the risk pool.

Individual health insurance purchase mandates would improve the economic incentives for individuals to purchase health insurance. Under most proposals to mandate health insurance purchase, a non-complying individual would face a significant monetary penalty.⁴⁹ Therefore, when an individual contemplates whether to purchase health insurance, he or she will take into account the cost associated with non-compliance with the mandate. The result should be that a greater number of low-risk individuals will purchase health insurance because of the additional cost

45. This would likely exclude 30% of the population. *See supra* text accompanying note 30.

46. *See* Jonathan Gruber & Larry Levitt, *Tax Subsidies For Health Insurance: Costs and Benefits*, 19 HEALTH AFF. 72, 78-79 (2000).

47. *See generally* KAISER COMMISSION ON MEDICAID AND THE UNINSURED, STATES MOVING TOWARD COMPREHENSIVE HEALTH CARE REFORM (2008), (available at http://www.kff.org/uninsured/kcmu_statehealthreform.cfm) [hereinafter KAISER COMMISSION].

48. When I use the term “sub-optimal” in this context I am referring to sub-optimal from a societal perspective. It may be possible that a given individual's decision to forgo health insurance is rational.

49. *See* KAISER COMMISSION, *supra* note 47, at 3.

imposed on forgoing such coverage.⁵⁰ By increasing the number of low-risk individuals who are insured, the overall risk level of the insured population should decline and premiums may decrease as a result. By creating a strong incentive to opt-in to the risk pool, health insurance purchase mandates would significantly strengthen social solidarity.⁵¹

3. Offer Mandates

Another reform option, sometimes proposed in tandem with the individual mandate discussed above, is to require employers to offer health insurance to their workers.⁵² This proposal is premised on taking advantage of both the preferential tax treatment granted to employer-provided health care coverage, as well as its group purchasing model.⁵³

I will refrain from an in-depth discussion of offer mandates, primarily because such mandates implicate the preemption provisions of ERISA, a meaningful discussion of which is beyond the scope of this comment.⁵⁴ However, the important question to be answered is whether offer mandates would meaningfully increase coverage rates. While many workers currently are either not offered coverage by their employer or are not

50. See Amy B. Monahan, *Pay or Play Laws, ERISA Preemption, and Potential Lessons from Massachusetts*, 55 U. KAN. L. REV. 1203, 1230-31 (2007) (discussing this possibility in the context of Massachusetts's health care reform legislation). Due to the likelihood of increased employee demand, these mandates may also encourage more employers to offer health insurance. See *id.* But see David A. Hyman, *The Massachusetts Health Plan: The Good, The Bad, and The Ugly*, 55 U. KAN. L. REV. 1103, 1111-12 (2007) (analogizing health insurance to automobile insurance mandates, which have led to less-than-universal coverage).

51. However, this is not a perfect solution if the maximization of risk sharing is our objective. Even if every state or the federal government were to require the purchase of health insurance, risk pools would remain stratified. Under our current system, state regulation of insurance results in state-level risk pools. See Christina H. Park, *Prevalence of Employer Self-Insured Health Benefits: National and State Variation*, 57 MED. CARE RES. & REV. 340, 342 (2000). Those pools are further stratified by self-insuring employers who have their own risk pools. *Id.* at 340, 342. However, creating the broadest possible risk pooling would require (1) moving the regulation of insurance to the federal level, (2) preventing employers from self-insuring their plans, and (3) requiring community rating and guaranteeing issue for all who apply. Given political realities, it may be too difficult to obtain such nationwide risk pooling.

52. See, e.g., MASS. GEN. LAWS ANN. ch.151F, § 2 (Supp. 2007).

53. Normative arguments are also made in support of offer mandates, arguing that employers have a responsibility to make health care coverage available to their workers.

54. See generally Monahan, *supra* note 50 for a discussion of ERISA preemption in the context of offer mandates.

eligible for such coverage—suggesting that significant improvement could be made by requiring employers to make such coverage available—30% of workers who are offered coverage decline it.⁵⁵ Because of the problem of non-universal enrollment in offered health insurance, offer mandates are often proposed in conjunction with purchase mandates.⁵⁶

4. Decreasing Micro-Level Risk Pooling

As we strive to find ways to increase health insurance coverage rates, and therefore macro-level risk pooling, there is increasing discomfort with mandated benefit laws, the primary vehicle for enforcing micro-level risk pooling.⁵⁷ The tension is this: as we increase micro-level risk pooling by requiring more treatments or services to be covered by health insurance contracts, we potentially raise prices and therefore decrease coverage rates. The two appear to have an inverse relationship. As a result, there is significant interest in eliminating or decreasing mandated benefit laws.⁵⁸

But, as will be explored further below, blaming mandated benefit laws for decreasing coverage rates oversimplifies the relationship. We cannot have effective macro-level risk pooling without having effective micro-level risk pooling. If we strip away all of our micro-level risk pooling, such that a health insurance contract protects only against the risk of loss associated with broken toes, we have not gained much social solidarity, even if we have universal coverage. I realize, of course, that we are not anywhere close to stripping health insurance down to broken toe coverage, but the point remains the same. It *matters* what gets covered by health insurance contracts. The problems associated with decreasing micro-level risk pooling are discussed in more detail below.

IV. AN EXAMINATION OF REGULATORY FEDERALISM

Professor Hyman critiques our current system of regulating the substance of health insurance contracts on many fronts. He makes an economic argument that our current regulatory system decreases welfare by providing consumers with the choice between “nothing but the best and

55. See Fronstin, *supra* note 28, at 1.

56. See, e.g., MASS. GEN. LAW. ANN. Ch.111M, § 2 (West, Supp. 2007).

57. See, e.g., Monahan, *supra* note 2, at 1401-13 (describing current legislative efforts to reduce the impact of or eliminated state mandated benefit laws).

58. See *id.*

nothing.”⁵⁹ He critiques mandated benefit laws as resulting from rent-seeking, rather than sound health policy,⁶⁰ and also makes a normative, libertarian argument regarding freedom to contract.⁶¹

In lieu of our current system of regulation, Professor Hyman advocates regulatory federalism with respect to health insurance. As he explains, “The goal is to identify the “Delaware” of health insurance regulation.”⁶² Under this system of regulatory federalism, health insurance purchasers could elect to buy insurance in any state, allowing such purchasers to elect the regulatory regime that will apply to their health insurance coverage.⁶³ For example, an individual who lives in Massachusetts but does not value Massachusetts’ mandated coverage for infertility treatment would be free to purchase coverage from Wyoming, where such coverage can be excluded from a health insurance contract.

On first glance, regulatory federalism does appear to fix many of the problems Professor Hyman has identified. Regulatory federalism would almost certainly be an effective counter to rent-seeking behavior. As Professor Hyman points out, a competitive regulatory environment would not allow states the luxury of special interest legislation.⁶⁴ If a state’s mandated benefit laws were not valued by the population, they would simply buy insurance elsewhere. States, not wanting to lose premium tax revenue, would likely be hesitant to grant economic rents to special interest groups. If rent-seeking is a primary concern, this appears to be a very effective solution.

The case for welfare maximization is somewhat less compelling. According to standard economic theory, consumers with free market choices will be able to satisfy their preferences and therefore maximize their welfare.⁶⁵ But let us examine *why* regulatory federalism would

59. Hyman, note 40, at 10 (internal citation omitted).

60. *Id.* at 5, 10. See also David A. Hyman, *Drive-Through Deliveries: Is “Consumer Protection” Just What the Doctor Ordered?*, 78 N.C. L. REV. 5, 92 (1999).

61. Hyman, *supra* note 40, at 10.

62. *Id.* at 11.

63. *Id.* at 11-12. Professor Hyman also proposes scaling back ERISA preemption by requiring even self-insured plans to elect a home jurisdiction for purposes of health plan regulation. *Id.* Further, he makes the novel proposal that states need not wait for federal legislation to allow inter-state purchasing. Rather, two or more states could voluntarily join together to allow their residents to purchase health insurance from any of the other participating states. *Id.* at 11.

64. *Id.* at 7.

65. See Cecil E. Bohanon, *A Comment on “Economic Inefficiency: A Failure of Economists,”* 21 J. ECON. EDUC. 427, 427-29 (1990).

increase some individuals' welfare. The benefit from regulatory federalism comes from purchasers being able to forgo coverage for certain treatments or services. This, in turn, will decrease the premium associated with the policy, leaving the purchaser with more money to spend on other desired items, thereby increasing the individual's welfare. The individuals with the most to gain under such a system are those with low health risks. For individuals with relatively high health risks, their welfare is arguably decreased. Granted, they should, in a functioning market, be able to maximize their welfare by freely entering into a contract that maximizes their preferences. However, adverse selection in health insurance purchasing creates market failure,⁶⁶ and allowing interstate purchase of health insurance will result in greater adverse selection problems. First, note that state mandated benefit laws rely on market restriction in order to function.⁶⁷ You cannot compulsorily share risk if individuals are free to opt-out of the mandate. Obviously, given the ability to opt-out, those who do not anticipate utilizing the benefit at issue will forgo such coverage. But now individuals who do not opt-out of the benefit will be signaling to the insurer that they expect to utilize the benefit, and the premium increase associated with the benefit will correspond to that expected utilization. Essentially, regulatory federalism would prevent community-wide risk spreading for the benefits at issue and instead spread risk only among the population expected to utilize the benefit. And this assumes that such coverage will continue to be available in an unrestricted market. Adverse selection may be such a problem that insurance coverage for "optional" benefits simply disappears. The fact that states will be competing for premium tax dollars makes this outcome even more likely, since state legislatures will likely move quickly to remove any mandates that are causing decreased enrollment in health insurance contracts governed by their state.⁶⁸

Regulatory federalism appears to satisfy libertarian ideals by providing freedom to contract, but only with respect to benefits unaffected by adverse selection. The market failure caused by adverse selection affects not only welfare maximization, but also the freedom to contract.⁶⁹ It is not simply that individuals will now be able to choose the contract terms they desire.

66. Katherine Swartz, *Justifying Government as the Backstop in Health Insurance Markets*, 2 YALE J. HEALTH POL'Y L. & ETHICS 89, 103 (2002).

67. Monahan, *supra* note 2, at 1410.

68. *Id.* at 1411-12 (discussing the impact that interstate sale of health insurance would likely have on the state legislative process).

69. Monahan, *supra* note 2, at 1385-86.

Because of adverse selection, the choice of contract terms with respect to health insurance is likely to be limited even in a free market. So low risk individuals will have the freedom to elect their contract terms (with lesser coverage terms), while certain high risk individuals will be unable to elect the broad coverage they may desire – falling short of the freedom to contract ideal.

We might be able to look past the negative effects of regulatory federalism on high-risk individuals if the end result is a significant increase in macro-level risk pooling by increasing the number of Americans who are insured. However, estimates suggest that allowing the interstate sale of health insurance, as Professor Hyman's proposal would permit, would not result in an increase in health insurance coverage. The Congressional Budget Office (CBO) recently prepared an estimate for proposed federal legislation allowing for interstate sale of health insurance.⁷⁰ The CBO cost estimate states simply that interstate sale of health insurance "would reduce the price of individual health insurance coverage for people expected to have relatively low health care costs, while increasing the price of coverage for those expected to have relatively high health care costs" resulting in an increase in the number of relatively healthy individuals, and a decrease in the number of individuals expected to have relatively high cost, who buy individual coverage" with little net effect on coverage rates.⁷¹ This conclusion is consistent with the analysis above regarding the likely outcome of regulatory federalism.

Professor Hyman's concerns about our current system of regulation are real, and should be addressed. But adopting regulatory federalism fundamentally undermines micro-level risk pooling, an important contributor to social solidarity.⁷² Micro-level risk pooling, after all, determines which medical risks will be shared. As a result, I am not ready to give up on the risk-pooling function of mandated benefit laws. Instead, we need to work to (1) identify permissible justifications for such laws⁷³ and (2) identify the proper procedure for drafting and adopting such laws.⁷⁴ If we can do a better job of regulating the substance of health insurance

70. CONG. BUDGET OFFICE, COST ESTIMATE REPORT ON H.R. 2355: HEALTH CARE CHOICE ACT OF 2005 1 (2005), available at <http://www.cbo.gov/ftpdocs/66xx/doc6639/hr2355.pdf>.

71. *Id.* at 7.

72. Monahan, *supra* note 2, at 1385, 1387.

73. See Amy B. Monahan, *Value-Based Mandated Health Benefits*, 80 U. COLO. L. REV. (forthcoming 2009).

74. Legislatures seem ill-suited to the task. See generally Hyman, *supra* note 60.

contracts we would move toward a health care system that effectively pools risk, strengthens social solidarity, and yet eliminates unnecessary costs.

CONCLUSION

The issues touched on in this Comment are not, by any means, easy. We want all Americans to have access to quality health care, which means we want all Americans to have health insurance coverage. We seem to be in agreement that, to one degree or another, we believe that health risks are appropriate to be shared. At the macro-level, the goal is easy. As we increase coverage, we increase risk-sharing and therefore social solidarity. But as we strive to increase macro-level risk sharing, we must be on guard against stripping away the micro-level coverage provisions. To decrease the cost of coverage we might be tempted to exclude more and more services from health insurance contracts. Even if such efforts do increase health insurance coverage, they will reduce social solidarity by eliminating the sharing of risk associated with the treatments at issue. As previously stated, we cannot have effective macro-level risk pooling without effective micro-level risk pooling. Professor Hyman has pointed out many of the problems with our current system of regulating micro-level risk pooling, to which we must respond not be giving up entirely, but by working to define both appropriate justifications and processes for regulating the substance of health insurance contracts.

THE HEALTH INSURANCE DEBATE IN CANADA: LESSONS FOR THE UNITED STATES?

Mary Anne Bobinski¹

I. INTRODUCTION

This Essay begins with an intentionally ambiguous title. Are comparisons to Canada relevant and useful for policy-makers in the United States and, if so, what lessons can we learn? Part II of this Essay highlights some of the risks and benefits of cross-border comparisons between the United States and Canada. In Part III, I analyze some of the key data points often cited in comparing the two health care systems. Part IV explores the current Canadian debate about private health insurance. Finally, in Part V, I focus on the lessons from Canada for the health insurance debate in the United States.

II. THE RELEVANCE OF COMPARISONS

Are comparisons to Canada relevant? Do they offer any value to policy makers or to the American public? The frequency of these comparisons might suggest that the answer is obvious. Yet there are substantial reasons to pause and consider when and how comparisons to Canada are truly relevant for the United States.²

¹ Dean and Professor of Law, University of British Columbia Faculty of Law. This Essay is based on a presentation originally given in January 2007 at the AALS Conference in Washington, D.C. The Essay was substantially revised, updated and submitted for publication in February 2008. The Essay's consideration of cross-border health law is paired with separate piece on the relevance of U.S. health law and policy for Canada. See *Judicial Responses to Government Restrictions on Health Care Markets in the US and Canada*, presented at the Visions National Health Law Conference in Banff, Alberta (November 10, 2007). The author wishes to thank commentators at the AALS Section on Insurance program in January 2007 for their questions and suggestions as well as Betsy Segal (UBC Law '07) and Brenda Osmond (UBC Law class '09) for research assistance.

² For a general discussion of the benefits and risks of comparative health policy analyses, see Timothy Stoltzfus Jost, *Comparative and International Health Law*, 14 HEALTH MATRIX 141 (2004). See also American College of Physicians, *Achieving a High-Performance Health Care System with Universal Access: What the United States Can Learn from Other Countries*, 148 ANNALS INTERN. MED. 55, 62-63 (2008) (noting difficulties of using comparative data but arguing that "the United States has much to learn by closely examining how other countries' health care systems tried to solve the problems that underlie

For many in the U.S., Canada is a cold country to the north, perhaps best known for maple syrup, ice hockey, natural beauty, and polite citizenry. Canada's proximity to the U.S. and the substantial economic ties between the two countries tend to promote the comparison industry. Canada seems familiar enough to create a natural quasi-empirical research study for U.S. policy makers interested in trying to predict the impact of changes in health care policy in the U.S. Advocates on both sides of the debate seem to believe that we can determine, for example, whether or not a single payer system would address the ills of the U.S. health care system by looking to the Canadian experience.

There are of course substantial differences between the two countries. Canada has roughly a tenth the population of the United States even though it is slightly larger in size.³ Despite Canada's vast geography, ninety percent of Canadians live within a few hours' drive of the U.S. border⁴ and a significant portion of Canada's economy is based on exports to the U.S.⁵ Canada has nonetheless retained its distinctive character, readily seen in areas ranging from the coexistence of English and French traditions and languages to a political and social climate generally viewed as significantly more "liberal" and less dominated by social conservatives than the United States. An illustrative list of the differences between the two countries would probably include Canada's failure to support the war in Iraq, the relatively swift legalization of same sex marriage, and Canada's pride in adopting a largely government-funded health care system.⁶

Over and above these significant differences in history, politics, and culture, so much of the debate about Canada seems to reveal more about the U.S. than it does about Canada itself. The U.S.-Canadian border – frequently referred to as "the longest undefended border in the world"⁷ – may not provide a clear window into an alternate reality so much as it

the United States' low-ranking performance"); Editor's Note, *Comparative Health Policy*, 26 J. H. POLITICAL POL'Y & L. 675.

³ The Central Intelligence Agency, "Canada," in *The World Factbook*, <https://www.cia.gov/library/publications/the-world-factbook/geos/ca.html> (updated regularly with new data).

⁴ *Id.* ("Geography-note . . . approximately 90% of the population is concentrated within 160 km of the US border").

⁵ *Id.* (Economy-overview section)

⁶ For a recent view on Canada's slight shift to the center or right, see Clifford Krauss, *Conservative Win in Canada Could Help Repair Ties to the U.S.*, N.Y. TIMES, Jan. 23, 2006, at A4.

⁷ See, e.g., Susan Catto, *Tighter Border Security Slows Canadian Traffic*, N.Y. TIMES, Apr. 6, 2003, sec. 5, at 3 (noting new post-9/11 security measures).

serves as a fun house mirror: reflecting back American concerns in exaggerated form rather than revealing relevant data about the impact of different systems of organizing and delivering health care.⁸ Is it accurate, relevant or useful to characterize the Canadian system as “socialized medicine” with health care providers fleeing to better paid jobs in the U.S. and Canadian citizens waiting in dangerously long lines for emergency or specialized care while government bureaucrats decide who will receive what types of care?⁹ Is it any more accurate, relevant or useful to describe the Canadian system as a nirvana in which society has accepted responsibility for providing basic health care for all and has developed an efficient, effective, and stable system of delivering on that commitment?¹⁰ The very terms of the debate – “socialized medicine” and “government bureaucrats” -- reveal more about the signposts of American political discourse than they do about the reality of the system they seek to describe.¹¹

Filmmaker Michael Moore’s indictment of the U.S. health care system, *Sicko*, provides a useful illustration of this problem.¹² The movie attempts to puncture the myths about Canada’s health care system through vignettes involving U.S. citizens seeking to qualify for coverage under the public system in Canada and Canadians who have received prompt care for their health conditions in Canada. The film thus includes an undoubtedly a humorous debunking of the negative stereotypes about the Canadian health care system often heard in political debates. Yet the Canadian reaction to the movie is somewhat complex. Canadians view their health care system as a source of national pride and identity and many Canadians undoubtedly

⁸ For a slightly different use of the mirror image, see KAREN DAVIS, ET AL., *MIRROR, MIRROR ON THE WALL: AN INTERNATIONAL UPDATE ON THE COMPARATIVE PERFORMANCE OF AMERICAN HEALTH CARE 1* (2007) (“Like the queen in the ‘Snow White’ fairy tale, Americans often look only at their own reflection in the mirror – failing to include international experience in assessments of the health care system.”), http://www.commonwealthfund.org/usr_doc/1027_Davis_mirror_mirror_international_update_final.pdf?section=4039.

⁹ The answer is “no,” of course. Among other things, medicine in Canada is not socialized: Canada has a single-payer system but most health care is provided by non-governmental institutions and private physicians. See William Lahey, *Medicare and the Law: Contours of an Evolving Relationship*, in CANADIAN HEALTH LAW AND POLICY 1, 13 (Jocelyn Downie, Timothy Caulfield, and Colleen Flood, eds., 3d ed. 2007).

¹⁰ The answer here is “no” as well. See text accompanying notes 70-71.

¹¹ For similar observations, see Peter S. Hussey, *Review, Health Systems in Transition: Canada*, 297 JAMA 647 (2007).

¹² See Michael Moore, *Sicko*, <http://www.michaelmoore.com/sicko/index.html> (last visited Nov. 23, 2008).

enjoyed the humorous comparisons between the two systems. But, at the same time, the movie's rosy glow created more than a few moments of discomfort for Canadian audiences given broad concerns about the sustainability of the current system and an intense debate about how to address lengthy waiting times for certain procedures.¹³

Given the risks of cross-border comparisons, this Essay therefore takes a skeptical, limited view of the relevance of the Canadian experience for the insurance debate in the United States. The next section of this Essay provides a basic outline of the Canadian system and then analyzes some recent data comparing Canada to the U.S. using data on health care expenditures, access and outcomes.

III. THE CANADIAN EXPERIENCE

A. THE CANADA HEALTH ACT

The Canada Health Act established a publicly-funded health care system that, confusingly enough for American readers, is called "Medicare."¹⁴ Much as occurred with the Medicaid system in the United States, the federal government in Canada used the lure of federal funding subsidies to induce provincial participation on a national health care program. Unlike the Medicaid system established in the U.S., the Canadian Medicare system is not viewed as a program designed to remedy the gap poverty creates in what is viewed as the presumptively efficient operation of the market for health insurance. The Canadian program as created by federal legislation and implemented in the various provinces instead largely

¹³ See, e.g., Jeffrey Simpson, *Sicko Lets Us Wallow In Our Health-Care Smugness*, THE GLOBE AND MAIL (Can.), July 11, 2007, at A17. See also Tracy Hampton, *7-Country Survey of Patients: US Adults Most Unhappy with Health Care*, 298 JAMA 2730 (2007) (while adults in the US are the most unhappy with their health care system, with 34% agreeing that the system needs to be rebuilt completely and 48% more citing the need for fundamental changes, many Canadians are worried as well. Twelve percent of Canadians think their system needs to be rebuilt and another 60 percent think that fundamental changes are needed).

¹⁴ The Canada Health Act, R.S.C. 1985, c. C-6. The Canada Health Act is available online at <http://www.canlii.org>. Although the Act is refreshingly brief and clear, particularly compared to health care legislation in the United States, the federal legislation and related provincial Acts have nonetheless spawned considerable litigation and academic commentary. For a general overview of the fundamentals of Canadian health care law, including the Medicare system, see Lahey, *supra* note 9, at 1-67.

supplants the private market for health insurance coverage for an important set of core health care services.

The Canadian Medicare system is characterized by five fundamental principles: accessibility, universality, portability, comprehensiveness, and public administration.¹⁵ Under the portability requirement, provinces must provide insurance coverage for lawful residents and are prohibited from imposing any waiting or eligibility period greater than three months.¹⁶ Provinces are also required to pay for the costs of health care incurred by residents who are temporarily away from their home province.¹⁷ The Medicare program's universality requirement establishes that provinces must provide insured persons access to services covered under the plan on the same terms and conditions.¹⁸ The accessibility of the system is maintained through provisions requiring the payment of providers from public funds that are coupled with provisions prohibiting extra billing or user charges.¹⁹ Comprehensiveness is created through the coverage of all medically necessary hospital services and medically required physician services.²⁰ The Act requires provinces to administer and operate their plans

¹⁵ Canada Health Act, R.S.C. 1985, c. C-6, § 7. *See also* Lahey, *supra* note 9, at 34-45 (discussing the criteria).

¹⁶ Canada Health Act, R.S.C. 1985, c. C-6, § 11 (“(1) In order to satisfy the criterion respecting portability, the health care insurance plan of a province (a) must not impose any minimum period of residence in the province, or waiting period, in excess of three months before residents of the province are eligible for or entitled to insured health services”). Under section 2, “resident” means, in relation to a province, a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province.” *Id.* at §2.

¹⁷ *Id.* at §11(1)(b).

¹⁸ Canada Health Act, R.S.C. 1985, c. C-6, § 10 (“In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions.”) Section 2 defines “insured persons” as “in relation to a province, a resident of the province” but excludes members of the Canadian Forces, members of the Royal Canadian Mounted Police (R.C.M.P.), penitentiary inmates, and provincial residents who have not yet completed their residency requirements. *Id.* at § 2.

¹⁹ Canada Health Act, R.S.C. 1985, c. C-6, § 12 (“In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province (a) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons”). Section 12 also establishes the requirements and general standards for the compensation of physicians, other practitioners, and hospitals. *Id.*

²⁰ Canada Health Act, R.S.C. 1985, c. C-6, § 9 (“In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all

through public entities on a non-profit basis, although health care can be provided through physicians who are not government employees.²¹

The principles of the Canadian system enjoy broad public support even though the system is saddled with some internal conflicts.²² Universality and portability imply uniformity but Canada's complex political landscape has tolerated deviations in independent-minded Quebec.²³ The system was more comprehensive at the outset than it is today, given developments that have moved care out of hospitals and away from physicians and toward pharmaceuticals, home care, and other services not included within the core Medicare mandate.²⁴ Provinces have addressed at least some of these challenges to comprehensiveness through programs layered on top of the core health services mandate; however the terms of provincial plans vary, leading to a lack of uniformity across Canada for some important types of health care.²⁵ Covered residents have access to the system without regard to their economic circumstances and need not fear the potentially crushing burden of deductibles and co-payments. But truly wealthy Canadians can "buy out" of the current system by seeking care in the United States and average Canadians may experience significant delays in accessing some services.

insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners"). Section 2 provides that "insured health services" means hospital services, physician services and surgical-dental services provided to insured persons" while excluding services provided under other federal legislation or provincial workers compensation regimes). "Medically necessary" and "medically required" are not defined within the Act or in provincial legislation. The implications of this gap are explored in, JUST MEDICARE: WHAT'S IN, WHAT'S OUT, HOW WE DECIDE (Colleen M. Flood, ed. 2006).

²¹ Canada Health Act, R.S.C. 1985, c. C-6, § 8.

²² See Lahey, *supra* note 9, at 66-67; and BUILDING ON VALUES: THE FUTURE OF HEALTH CARE IN CANADA: FINAL REPORT (2002) [The Romanow Report], http://www.hcsc.gc.ca/english/pdf/romanow/pdfs/HCC_Final_Report.pdf.

²³ See Lahey, *supra* note 9, at 47 (noting Quebec's refusal "to reimburse other provinces (except Ontario) at the rates of the other province for services provided to Quebec residents").

²⁴ *Id.* at 21-23. Drug therapies are covered under the Canada Health Act when administered in a hospital. Provinces have gone beyond the Act's requirements by establishing publicly funded pharmaceutical assistance programs, though there is considerable variation in coverage and patient costs. *Id.*

²⁵ *Id.*

B. HEALTH EXPENDITURES IN CANADA AND THE UNITED STATES

Health care expenditures take a central position in many debates about health care. Rising health expenditures have been taking a larger and larger share of gross domestic product (GDP) in both Canada and the United States. In 2006, per capita health care expenditures in Canada rose to \$3,678 or 10% of the GDP.²⁶ In Canada, public sources generally pay for about 70% of health expenditures with the private sector picking up the remaining 30%.²⁷ Super-inflationary increases in health care expenditures mean that health care occupies a larger and larger share of provincial expenditures. Private insurance and private payment cover goods and services not within the core Medicare mandate.

Health care expenditures in the United States increased to \$6,714 per capita or 15.3% of the GDP in 2006.²⁸ In the mid-1960s, before the introduction of Medicare and Medicaid, the public and private share of health expenditures were the mirror image of the distribution found in Canada, with the private sector picking up 70% of the costs of health care and the public sector paying for 30%.²⁹ The public share of health expenditures reached 40% by 1978 and stood at 45.8% in 2006.³⁰ Increases in health care spending have had a disproportionate impact on state and local government budgets.³¹

Both Canada and the United States spend more per capita and as a percentage of GDP than many other developed countries. The median rate of health care spending per capita for the thirty Organisation for Economic

²⁶ *OECD Health Data 2008 - Frequently Requested Data* [hereinafter “*OECD Health Data 2008*”] (MS Excel document; 2006 expenditures measured in “U.S.\$, purchasing power parity”), http://www.oecd.org/document/16/0,3343,en_2649_34631_2085200_1_1_1_1,00.html. See also Canadian Institute for Health Information, *Health Care in Canada 2007* 9-10 (2007), http://secure.cihi.ca/cihiweb/products/hcic2007_e.pdf

²⁷ *OECD Health Data 2008*, *supra* note 26. See also National Health Expenditure Trends, 1975-2007 9-10 (2007), http://secure.cihi.ca/cihiweb/products/NHET_1975_2007_e.pdf.

²⁸ *OECD Health Data 2008*, *supra* note 26.

²⁹ *Id.*

³⁰ *Id.*

³¹ Aaron Catlin, et al., *National Health Spending In 2006: A Year of Change for Prescription Drugs*, 27 *HEALTH AFFAIRS* 14, 21 (2008) (Exhibit 5). The state and local share of public health care expenditures has been close to 13% since 1990 but this relative stability masks the fact that state and local spending on Medicaid has tripled during this same time period while federal expenditures have grown 2.5 times and total expenditures have only doubled. *Id.*

Cooperation and Development (OECD) countries in 2006 was \$2,898 (US) or 8.9% of GDP.³² The U.S. led the OECD countries in per capita costs and percentage of GDP (at \$6,714 and 15.3%) while Canada ranked fifth in spending and eighth in percentage of GDP (at \$3,678 and 10%).³³ The excellent comparative data on health care spending is relative rather than normative: we can compare how much countries spend but we have no definitive measure of how much would be the correct amount.³⁴ Commentators therefore turn to other types of data that more readily permit evaluation of the results of health care spending. Two major areas of comparison involve access and health care outcomes.

C. ACCESS TO HEALTH CARE IN CANADA AND THE UNITED STATES

Access to health care can be measured in different ways. Levels of health insurance coverage are clearly important, as health care costs can rapidly outstrip the ability of people to pay directly for their own health care. Yet, as increases in the percentage of GDP allocated to health care have vividly demonstrated, every society must manage trade-offs between spending on health care and spending on other goods and services. Restrictions on health care spending are managed through some form of rationing conducted at some level of the system.³⁵ The method of rationing

³² *OECD Health Data 2008*, *supra* note 26 (derived from 2006 data). *See also* Gerard F. Anderson, Bianca K. Frogner, and Uwe E. Reinhardt, *Health Spending in OECD Countries in 2004: An Update*, 26 HEALTH AFFAIRS 1481, 1483 (2007) [hereinafter Anderson, Frogner & Reinhardt, *Health Spending 2004*] (Exhibit 1) and Gerard F. Anderson, Bianca K. Frogner, Roger A. Johns, and Uwe E. Reinhardt, *Health Care Spending And Use Of Information Technology In OECD Countries*, 25 HEALTH AFFAIRS 819, 820 (2006).

³³ *OECD Health Data 2008*, *supra* note 26 (derived from 2006 data). *See also* Anderson, Frogner & Reinhardt, *Health Spending 2004*, *supra* note 32, at 1483 (Exhibit 1).

³⁴ *See generally*, William D. Savedoff, *What Should A Country Spend on Health Care?*, 26 HEALTH AFFAIRS 962 (2007) (noting issue and analyzing different approaches).

³⁵ "Rationing" is a somewhat vague term used in different ways in different contexts. *See, e.g.*, Roy G. Spece, Jr., *A Fundamental Constitutional Right of the Monied to "Buy Out of" Universal Health Care Program Restrictions Versus the Moral Claim of Everyone Else to Decent Health Care: An Unremitting Paradox of Health Care Reform?*, 3 J. HEALTH & BIOMEDICAL L. 1, 14-15 (2007). The admittedly expansive definition of rationing used in this Essay is meant to cover everything from restrictions on the supply of health care providers or type of care, to bedside rationing and waiting lists for services, to rationing based on access to health insurance or wealth. In the global sense, "rationing" simply refers to the process of aligning limited health care resources or funding with the not-so-limited health care needs of the population.

directly affects access to care because it defines who has access to what and when.

Canada clearly wins compared to the United States whenever access is measured by the percentage of the population with health insurance. Canada provides health insurance coverage for nearly all of its legal residents. In the United States, more than 45 million people – representing more than 15% of the population – are uninsured with many millions more underinsured from the risk of catastrophic health care costs. In total, “[a]n estimated one-third of U.S. adults are either uninsured during the year or underinsured.”³⁶

Accessibility can also be compared using the method and impact of rationing employed within a society. Some types of health care are rationed through waiting lists in Canada as well as in other countries offering universal coverage.³⁷ In the United States, most types of care are not rationed through waiting lists.³⁸ Instead, certain portions of the population are left uninsured or underinsured and therefore are denied care altogether or face delays and the risk of substandard care.³⁹ In the aggregate, the result is that Canadians fare better than Americans: “[c]ompared with Canadians, US residents are one third less likely to have a regular medical doctor, one fourth more likely to have unmet health care needs, and more than twice as likely to forego needed medicines.”⁴⁰ However the U.S. results were not uniform: insured Americans reported slightly better access to care and receipt of services than Canadians.⁴¹ Uninsured Americans generally fared much worse than Canadians.⁴²

Accessibility is related to the supply of physicians (or other health care professionals), hospital beds, and specialized medical equipment.

³⁶ Cathy Schoen, et al., *Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries*, 2007, HEALTH AFFAIRS w717, 718 (2007).

³⁷ Kristen Boyle, *A Permanent Vacation: Evaluating Medical Tourism's Place in the United States Healthcare System*, HEALTH LAW, June 2008, at 42.

³⁸ One notable exception – at least for the moment -- involves the transplantation of scarce organs. Organs are allocated from a waiting list rather than through the market. See Troyen Brennan, *Markets in Health Care: The Case of Renal Transplantation*, 25 J. L. MED. & ETHICS 249 (2007).

³⁹ See, e.g., Sharon Wilcox, et al., *Measuring and Reducing Waiting Times: A Cross-National Comparison of Strategies*, 26 HEALTH AFFAIRS 1078, 1078-79 (2007).

⁴⁰ Karen E. Lasser et al., *Access to Care, Health Status, and Health Disparities in the United States and Canada: Results of a Cross-National Population-Based Survey*, 96 AMER. J. PUB. HEALTH 1300, 1303 (2006).

⁴¹ *Id.* at 1303, 1304.

⁴² *Id.*

Interestingly, despite record setting expenditures on health care, the United States does not lead the world in various measures of health care supply.⁴³ Both Canada and the U.S. have fewer physicians per 1,000 persons than the OECD median.⁴⁴ Canada appears to use its physicians more efficiently than the U.S. and is at the median of OECD countries with 5.9 physician consultations per capita compared to 4 in the United States.⁴⁵ Canada does have fewer practicing nurses per 1,000 population (8.8) than the U.S. (10.5); in this area the U.S. is above the OECD median (9.8).⁴⁶ Similarly, Canada has more acute care beds per 1,000 population than the United States though both are below the OECD median.⁴⁷

Canada maintains universal coverage for physician and hospital services, which explains why Canadians in general have better access to health care than Americans. But Canada rations access to certain types of care through waiting lists and those waiting lists have become a major legal and political issue. Studies repeatedly find that Canadians wait longer for certain elective procedures than Americans.⁴⁸ A recent survey found that:

⁴³ *OECD Health Data 2008*, *supra* note 26 (derived from 2006 data). *See also* Anderson, Frogner, & Reinhardt, *Health Spending 2004*, *supra* note 32, at 1485 (Exhibit 2). This counterintuitive result is related in part to the fact that the price for health care is higher in the U.S.:

Although these are crude measures, the low resource levels and low utilization rates coupled with the high level of health care spending in the United States suggest that U.S. prices for health resources are higher than in other OECD countries. The high level of spending on U.S. health care may reflect that the system more quickly adopts expensive new technology and pays much higher prices for the real resources used in health care.

Anderson, Frogner, & Reinhardt, *Health Spending 2004*, *supra* note 32, at 1484.

⁴⁴ *OECD Health Data 2008*, *supra* note 26 (derived from 2006 data). There were 2.4 practicing physicians per 1,000 population in the U.S. and 2.1 in Canada in 2006 compared to the OECD median of 2.94. *See also* Anderson, Frogner, & Reinhardt, *Health Spending 2004*, *supra* note 32, at 1485 (Exhibit 2).

⁴⁵ *OECD Health Data 2008*, *supra* note 26 (derived from 2005 data). *See also* Anderson, Frogner, & Reinhardt, *Health Spending 2004*, *supra* note 32, at 1485 (Exhibit 2).

⁴⁶ *OECD Health Data 2008*, *supra* note 26 (2006 data on practicing nurses, density per 1,000). *But see* Anderson, Frogner, & Reinhardt, *Health Spending 2004*, *supra* note 32, at 1485 (Exhibit 2) (reporting more nurses per capita for Canada in 2004).

⁴⁷ *OECD Health Data 2008*, *supra* note 26 (2.7 acute care beds per 1,000 population for the U.S. and 2.8 for Canada in 2005; the OECD average was 3.9). *See also* Anderson, Frogner, & Reinhardt, *Health Spending 2004*, *supra* note 32, at 1485 (Exhibit 2) (similar).

⁴⁸ *See, e.g.*, Cathy Schoen et al., *supra*, note 36, at 720 ("German and US adults reported the most rapid access and Canadian and British adults, the longest waits"); and Cathy Schoen, et al., *U.S. Health System Performance: A National Scorecard*, 26 HEALTH AFFAIRS w457, w458 (2006).

Although more US respondents had unmet health care needs than did Canadians (13.2% and 10.7%, respectively), their reasons for having such needs differed. Seven percent of US respondents (and less than 1% of Canadians) had unmet needs because of financial barriers, whereas 3.5% of Canadians had unmet needs because of waiting times (vs. less than 1% of US residents).⁴⁹

In another recent survey, 11% of Canadians and 16% of Americans reported having had elective surgery in the past two years.⁵⁰ Only thirty-two percent of the Canadian respondents received their elective surgery in less than a month compared to 62% of respondents from the U.S.; 14% of the Canadians waited more than six months, compared to only 4% of the Americans.⁵¹

In some areas, Canada and the U.S. both fare badly compared to some other developed countries. Survey respondents in both countries reported difficulties in securing same day physician appointments and were more likely than respondents from other countries “to report long waits (six days or more) to see a doctor when sick.”⁵² Respondents from both countries were also more likely to have sought care, sometimes inappropriately, from an emergency room.⁵³ Canadians were the most likely to have waited two or more hours in the emergency room (at 46%).⁵⁴ Americans had the fourth highest percentage of persons waiting two hours or more (at 31%).⁵⁵

In summary, Canadians generally have better access to health care than Americans as a whole though insured Americans report slightly better results in some areas. Both Canada and the U.S. are confronting some challenges regarding the supply of health care providers and hospital beds. More Canadians than Americans report delays in receiving some types of care.

Access to care is important but not necessarily for its own sake so much as because health care is related to positive health care outcomes. We

⁴⁹ Lasser, *supra* note 40, at 1303.

⁵⁰ Schoen et al., *supra* note 36, at w721 (Exhibit 2).

⁵¹ *Id.*

⁵² Schoen, et al., *supra* note 36, at w724. Thirty percent of Canadian respondents reported waiting six or more days compared to 20% of US respondents. *Id.* at w725 (Exhibit 4).

⁵³ *Id.* at w724-w725 (including Exhibit 4).

⁵⁴ Schoen, et al, *supra* note 36, at w725 (Exhibit 4).

⁵⁵ *Id.*

care whether people have access to physicians, hospitals, and emergency rooms because access to care bears at least some relationship to the length and quality of people's lives.⁵⁶ As will be seen in the next section, the U.S. does not fare particularly well on measures of health care outcomes compared to Canada or many other countries.

D. HEALTH CARE OUTCOMES IN CANADA AND THE UNITED STATES

There are many measures of health care outcomes. Efforts to "rate" the success of health care systems using multiple criteria and indicators are increasingly common. Researchers associated with the Commonwealth Fund have developed an analysis that uses data on the "Quality of Care," "Access," "Efficiency," "Equity," and "Healthy Lives."⁵⁷ Unfortunately, [t]he U.S. ranks last overall across the five dimensions of a high performance health system" when compared to Australia, Canada, Germany, New Zealand, and the United Kingdom.⁵⁸ Yet Canada received the next worst results, coming in 5th out of the 6 countries studied.⁵⁹ Using

⁵⁶ It is important, however, not to overstate the role of health care. There are significant variations in morbidity and mortality that appear largely unrelated to access to health care. For a summary of factors influencing health, see Canadian Institute for Health Information, *supra* note 26, at 45 (noting that relevance of socio-economic status, social environment and support networks, employment/working conditions, physical environments, personal health practices, healthy child development, biology and genetic endowment, and gender).

⁵⁷ DAVIS, ET AL., *supra* note at 8, at 4. Each of these five categories is in turn broken into subparts and measured using multiple benchmarks. "Quality of care" provides a somewhat complicated example of this process. "Quality of care" is "defined . . . as care that is effective or 'right,' safe, coordinated and patient-centered." *Id.* at 6. Each of these subcategories is measured using specific indicators. "Right care measures" include indicators such as the percentage of women in certain age groups who have had a Pap test within the past two years and the percentage of diabetics receiving certain identified services. *Id.* "Safe care" indicators are measures of errors in the health care system, such as being given the wrong medication. *Id.* at 9. "Coordinated care" measures whether patients have a regular doctor and whether the system collects and coordinates information about care. *Id.* at 11. "Patient-centeredness" is defined as "care delivered with the patient's needs and preferences in mind." *Id.* at 12. The benchmark criteria include communication, continuity and feedback, and the level of engagement and concern with patient preferences. *Id.* at 12. Quality of care is the most complex category of measures but the scores for "Access," "Efficiency," "Equity," and "Healthy Lives" are determined using a similar process.

⁵⁸ DAVIS, ET AL., *supra* note at 8, at 4.

⁵⁹ *Id.* at viii (Figure ES-1. Overall Ranking).

these global measures, the Canadian system produces better results than the U.S. system, but both could benefit from improvement.

These global measures of system quality have the virtue of combining a wide range of comparative data about health care systems. Yet as victims of the U.S. News and World Report ranking system for law schools can attest, ranking systems appear to offer numerical precision while sometimes obscuring the important value choices inherent in picking some indicators over others or weighing some results over others.⁶⁰ It might therefore be helpful to “drill down” into the results for some specific outcome indicators in the United States and Canada.⁶¹

Two frequently cited indicators are infant mortality and length of life. As is now well known, the United States does not fare particularly well on these measures as compared to Canada and many other countries. In 2005, the U.S. had a relatively high rate of infant mortality (7.0) compared to Canada (5.4); neither country was a particular success story compared to others around the world.⁶²

Life span can be measured in several ways.⁶³ One increasingly popular method focuses on the rate of preventable death and healthy life expectancy.⁶⁴ The rate of preventable death or “amenable mortality” “refer[s] to deaths from certain causes that should not occur in the presence of timely and effective health care.”⁶⁵ Examples include deaths from “conditions such as bacterial infections, treatable cancers, diabetes, cardiovascular and cerebrovascular disease, and complications of common

⁶⁰ See, e.g., Law School Admissions Council, *Ranking Law Schools*, <http://www.lsac.org/Choosing/deans-speak-out-rankings.asp> (last visited Nov. 23, 2008).

⁶¹ The selection of indicators also represents a value choice. In this case, I have chosen indicators based on the broad popularity of these measures in comparative health studies.

⁶² DAVIS, ET AL., *supra* note at 8, at 21 (Figure 8). For the current comparative data see Central Intelligence Agency, Rank Order—Infant Mortality, in *The World Factbook*, <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2091rank.html>.

⁶³ Canada and the U.S. can be compared on average life expectancy as well as healthy life expectancy at age 60. In 2008, Canada was ranked 8th in the world for life expectancy at birth (81.16 years) compared to the United States, which was ranked 46th (at 78.14 years). CIA, Rank Order – Life Expectancy at Birth, in *The World Factbook*, <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2102rank.html>

(website updated regularly with most recent data). Canada also bests the U.S. in average healthy lives expectancy at age 60 (18 years in Canada compared to 17 in the U.S.). DAVIS, ET AL., *supra* note at 8, at 21 (citing 2003 WHO data).

⁶⁴ DAVIS, ET AL., *supra* note at 8, at 21.

⁶⁵ Ellen Nolte & C. Martin McKee, *Measuring the Health of Nations: Updating an Earlier Analysis*, 27 HEALTH AFFAIRS 58, 59 (2008).

surgical procedures.”⁶⁶ The United States has a higher rate of amenable mortality than Canada (96.41 compared to 68.15) and has not been reducing the rate of amenable mortality as quickly as many other countries.⁶⁷ Thus, “by 2002-03, the United States had among the highest amenable mortality rates of countries studied, for both males and females.”⁶⁸

This data on health status and outcomes reinforces the conclusion that the Canadian health care system produces better access to better care with better outcomes and at lower cost than the United States. At the same time, it is clear that both Canada and the United States fare poorly compared to other OECD countries on many of these measures. Further, while the United States struggles to broaden access to care within a system that favors a private health insurance market, Canada’s public health care system is confronting challenges related to costs, comprehensiveness, and waiting times. Comparisons between the two countries invariably focus on the balance of public and private sector responsibility for health care. The next section of this Essay will explore the Supreme Court of Canada’s recent foray into the debate.

IV. THE CANADIAN INSURANCE DEBATE

A. THE PUBLIC-PRIVATE DEBATE IN CANADA

Despite the title of this section, it is important to recognize the limited nature of the debate about the roles of the public and private sectors in Canada. As noted above, the Canadian Medicare program is a source of national pride and identity. There is thus no real interest among Canadians or their politicians in changing the fundamental character of the health care system away from a publicly supported, universal and comprehensive system of care. In addition, there is little interest in affirmatively developing anything that might be called a “two-tier” system of health care: one in which a public health care system is coupled with a vigorous private market for health care services. “Two-tier” is a symbolic touchstone –

⁶⁶ *Id.* (researchers also included ½ the deaths from ischemic heart disease (IHD) based on evidence that half the deaths in this category are preventable).

⁶⁷ *Id.* at 62 (Exhibit 2).

⁶⁸ *Id.* at 63. Improving U.S. scores to the average of eighteen studied OECD countries would prevent 75,000 deaths of persons under age 75 per year. *Id.* For a similar analysis, see DAVIS, ET AL., *supra* note at 8, at 21 (Canada is 3rd and U.S. is 6th in ranking of six countries based on mortality amenable to health care).

playing much the same role as the phrase “socialized medicine” does in the United States – and the phrase generally means “bad” in any policy debate. Indeed, one Canadian critique of the U.S. is that it has created a two-tiered system in which the public programs have suffered from the emphasis on the private market with the result that health care is allocated based on ability to pay rather than need.

Of course it could well be argued that Canada already has a two-tiered system, at least in some respects. The private sector pays for thirty percent of health care costs in Canada, in part because the Medicare program does not include within its core mandate increasingly important types of health care such as out-of-hospital pharmaceuticals and home health care.⁶⁹ In addition, the wealthiest Canadians are capable of paying for care directly from a limited number of private clinics in Canada or at health care facilities in the U.S. or elsewhere. But it is important to recognize that these examples typically inspire calls to expand or to improve the Medicare program rather than creating a sense of comfort with the notion of privatized care.

The Canadian health care system is under enormous pressure due to increasing costs, insufficiencies in the supply of health care providers, expanding waiting lists, and the anticipated impact of an aging population. Commissions and academics have issued numerous reports on the future of the health care system. By and large, these reports reaffirm the centrality of the public’s role in funding and administering the delivery of health care in Canada. Two particularly prominent recent reports, the Romanow Report⁷⁰ and the Kirby Report,⁷¹ both concluded that Canada’s emphasis on public responsibility for health care should be maintained. For all of these reasons, the Supreme Court of Canada’s recent decision in *Chaoulli v. Québec* (Attorney General) generated considerable controversy.⁷²

B. OVERVIEW OF THE *CHAOULLI* CASE AND (JUST A BIT OF) CANADIAN CONSTITUTIONAL LAW

⁶⁹ Martha Livingston, *Update on Health Care in Canada: What’s Right, What’s Wrong, What’s Left*, 19 J. PUB. HEALTH POL’Y 267, 271, 279 (1998). See also *supra* note 24.

⁷⁰ See The Romanow Report, *supra* note 22.

⁷¹ THE HEALTH OF CANADIANS – THE FEDERAL ROLE, VOLUME SIX: RECOMMENDATIONS FOR REFORM (Standing Senate Committee on Social Affairs, Science and Technology) (2002) [hereinafter The Kirby Report] (known as the Kirby Report after Senator Kirby), <http://www.parl.gc.ca/37/2/parlbus/commbus/senate/Com-e/soci-e/rep-e/repoct02vol6-e.htm/>.

⁷² *Chaoulli v. Québec* (Attorney General), [2005] 1 S.C.R. 791 (Can.).

The *Chaoulli* case was initiated by a patient, George Zeliotis, and a physician, Jacques Chaoulli.⁷³ Mr. Zeliotis had become a critic of waiting lists after experiencing delays while receiving treatment for various medical conditions.⁷⁴ Dr. Chaoulli had previously unsuccessfully sought provincial recognition of his home-delivered medical services as well as a license to open a private hospital.⁷⁵ The plaintiffs sought a declaration that two specific provisions of Québec law violated the both Quebec Charter⁷⁶ and the Canadian Charter of Rights and Freedoms.⁷⁷ The challenged provisions prohibited the sale of private health insurance for health care covered under the provincial Medicare plan.⁷⁸ These prohibitions appeared to be designed to support the public health system by preventing the development of privately funded care.

⁷³ *Id.* at 807.

⁷⁴ *Id.* at 792.

⁷⁵ *Id.* at 792-93.

⁷⁶ Charter of human rights and freedoms, R.S.Q. c. C-12 (Can.) [hereinafter the "Quebec Charter"], <http://www.canlii.org/qc/laws/sta/c-12/20071213/whole.html>.

⁷⁷ The Constitution Act, 1982, being Schedule B to the Canada Act 1982 (U.K.), 1982, c. 11 (Can.) [hereinafter the "Canadian Charter of Rights and Freedoms" or the "Canadian Charter"], <http://www.canlii.org/en/ca/const/const1982.html>.

⁷⁸ The first contested provision prohibited private coverage of "insured services" – that is, those covered under the provincial medical plan:

15. No person shall make or renew a contract of insurance or make a payment under a contract of insurance under which an insured service is furnished or under which all or part of the cost of such a service is paid to a resident or a deemed resident of Québec or to another person on his behalf.

Health Insurance Act, R.S.Q., c. A-29. *See Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791, 911 (Can.) (Appendix) The second contested provision was similar but focused on hospitalization services covered under the provincial plan:

11. (1) No one shall make or renew, or make a payment under a contract under which

(a) a resident is to be provided with or to be reimbursed for the cost of any hospital service that is one of the insured services;

(b) payment is conditional upon the hospitalization of a resident; or

(c) payment is dependent upon the length of time the resident is a patient in a facility maintained by an institution contemplated in section 2.

(2) This section does not apply . . . [during the waiting period for provincial coverage].

Hospital Insurance Act, R.S.Q., c. A-28. *See Chaoulli*, 1 S.C.R. 791, 911-12 (Appendix).

The Quebec Charter is a provincial document that, while not strictly speaking a constitution, does give courts the ability to review and to strike down inconsistent provincial legislation. Section 1 of the Quebec Charter provides that “Every human being has a right to life, and to personal security, inviolability and freedom.”⁷⁹ The Quebec Charter also includes a type of “savings clause,” under which legislation that appears to violate §1 can nonetheless be justified and preserved. Section 9.1 of the Quebec Charter provides: “In exercising his fundamental freedoms and rights, a person shall maintain a proper regard for democratic values, public order and the general well-being of the citizens of Québec. . . . In this respect, the scope of the freedoms and rights, and limits to their exercise, may be fixed by law.”⁸⁰ The Supreme Court of Canada had previously found that §9.1 was similar to §1 of the Canadian Charter, discussed below, and that the government could be required to demonstrate that “the restrictive law is neither irrational nor arbitrary and that the means chosen are proportionate to the end to be served.”⁸¹

The Canadian Charter establishes the broader power of the courts to overturn any federal or provincial legislation inconsistent with its provisions.⁸² Section 7 of the Canadian Charter provides that “Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.”⁸³ There are two parts to the §7 analysis: determining whether there has been a deprivation of a protected right and then determining whether the deprivation is nonetheless consistent with the principles of fundamental justice. As would be expected, there is a substantial body of case law and commentary interpreting the provisions of §7 and other aspects of the Canadian Charter.⁸⁴

In addition, §1 of the Canadian Charter allows courts to uphold legislation depriving individuals of their §7 rights in certain circumstances.

⁷⁹ Charter of human rights and freedoms, R.S.Q. c. C-12, § 1 (Can.), <http://www.canlii.org/qc/laws/sta/c-12/20071213/whole.html>.

⁸⁰ *Id.* at art. 9.1; *Chaoulli*, 1 S.C.R. at 821 (Deschamps, J.)

⁸¹ *Chaoulli*, 1 S.C.R. at 821-23 (Deschamps, J.) (citing *Ford v. Quebec (Attorney General)*, [1988] 2 S.C.R. 712 (Can.)) Justice Deschamps therefore noted that the *Oakes* test developed under §1 of the Canadian Charter would be applied to determine whether the legislation could be justified under §9.1 of the Quebec Charter. *See* notes 86-87, *infra*.

⁸² *The Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 (Can.), <http://www.canlii.org/en/ca/const/const1982.html>.

⁸³ *Id.* at §7.

⁸⁴ *See generally* PETER HOGG, CONSTITUTIONAL LAW OF CANADA (5th ed. 2007) (two volumes).

Section 1 provides: “The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.”⁸⁵ Canadian courts use the “*Oakes* test” to carry out the §1 analysis critical to determining whether or not to strike down legislation that deprives someone of his or her §7 rights.⁸⁶ Under this test:

First, the court must determine whether the objective of the legislation is pressing and substantial. Next, it must determine whether the means chosen to attain this legislative end are reasonable and demonstrably justifiable in a free and democratic society. For this second part of the analysis, three tests must be met: (1) the existence of a rational connection between the measure and the aim of the legislation; (2) minimal impairment of the protected right by the measure; and (3) proportionality between the effect of the measure and its objective⁸⁷

The tests of rationality, minimal impairment, and proportionality have also been applied to determine whether restrictive legislation can be justified under §9.1 of the Quebec Charter.⁸⁸

The plaintiffs were unsuccessful in bringing their Canadian Charter and Quebec Charter claims in the lower courts. The trial court dismissed the motion for a declaratory judgment under the Canadian Charter without specifically considering the Quebec Charter.⁸⁹ The trial court found that the provincial legislation did infringe the right to life, liberty and security of the person under §7 of the Canadian Charter but held that the deprivation did not violate the principles of fundamental justice. It did not need to reach the §1 analysis but nonetheless indicated that it would have upheld the legislation as justified under §1. The plaintiffs’ appeal was thereafter

⁸⁵ *The Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11, §1 (Can.), <http://www.canlii.org/en/ca/const/const1982.html>.

⁸⁶ *Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791, 823 (Can.) (Deschamps, J.). The test was developed in *R. v. Oakes*, [1986] 1 S.C.R. 103 (Can.).

⁸⁷ *Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791, 823 (Can.) (Deschamps, J.) (citing *R. v. Oakes*, [1986] 1 S.C.R. 103 (Can.)).

⁸⁸ See *Chaoulli*, 1 S.C.R. at 822-23 (Deschamps, J.) (citing *Ford v. Quebec (Attorney General)*, [1988] 2 S.C.R. 712 (Can.)).

⁸⁹ *Id.* at 807-08.

dismissed by the Court of Appeal, with each of the panel judges writing a separate opinion.⁹⁰ Again, none of the judges drew specific attention to the Quebec Charter.

Given the treatment of the plaintiffs' claims in the courts below, and the iconic status of Canada's public health system, it was somewhat of a surprise when the Supreme Court of Canada struck down Quebec's ban on private health insurance in a 4:3 decision. The justices split 3:3 on the question of whether the legislation violated §7 of the Canadian Charter and whether it could be justified under §1.⁹¹ The deciding vote and narrow basis of the decision were therefore crafted by Justice Deschamps, who found that the Quebec legislation violated §1 of the Quebec Charter and that it could not be justified under §9.1 of that document.⁹² She did not reach the claims under the Canadian Charter.

The opinions of the justices are detailed and comprehensive; the entire decision is nearly 100 pages long.⁹³ A number of important Canadian commentaries already have been published on the decision and its implications.⁹⁴ For our purposes, we need only focus on two aspects of the debate between the justices of the Supreme Court of Canada. First, we will analyze the court's treatment of whether the ban on private health insurance intruded into a right protected by the Quebec Charter or the Canadian

⁹⁰ *Id.* at 809.

⁹¹ Chief Justice McLachlin and Justice Major wrote an opinion, joined by Justice Bastarache, finding that

“[w]e concur in the conclusion of our colleague Deschamps J. that the prohibition against contracting for private health insurance violates s. 1 of the Quebec Charter of Human Rights and Freedoms, R.S.Q., c. C-12, and is not justifiable under s. 9.1. On the argument that the anti-insurance provision also violates s. 7 of the Canadian Charter of Rights and Freedoms (“Charter”), we conclude that the provision impermissibly limits the right to life, liberty and security of the person protected by s. 7 of the Charter and has not been shown to be justified as a reasonable limit under s. 1 of the Charter.

See Chaoulli, 1 S.C.R. at 843 (Can.) (McLachlin, C.J., and Major, J., concurring)). Justices Binnie and LeBel, joined by Justice Fish, were unwilling to find a violation of the Quebec Charter or the Canadian Charter. *Id.* at 860-911 (Binnie & LeBel, JJ., dissenting).

⁹² *Id.* at 805-42 (Deschamps, J.).

⁹³ The narrow opinion by Justice Deschamps will be referred to herein as the “majority” decision; the opinion by the Chief Justice and Justice Major is the concurring opinion and the opinion by Justices Binnie and LeBel is the dissenting opinion.

⁹⁴ *See, e.g.*, ACCESS TO CARE, ACCESS TO JUSTICE: THE LEGAL DEBATE OVER PRIVATE HEALTH INSURANCE IN CANADA, 257-77 (Colleen M. Flood et al., eds., 2005) [hereinafter ACCESS TO CARE]; Symposium on *Chaoulli*, 44 OSGOODE HALL L.J. 249 (2006) [hereinafter Symposium on *Chaoulli*].

Charter. Second, we will explore the court's analysis of whether the ban on private health insurance was rationally related to the continued existence of the public health care system itself. The implications of these aspects of *Chaoulli* decision for United States will then be explored in the final Part of this Essay.

C. DID THE PROHIBITION ON PRIVATE HEALTH INSURANCE DEPRIVE THE PLAINTIFFS OF A PROTECTED RIGHT?

It is not necessarily easy to draw a line from a provincial ban on private health insurance to the freedoms protected under the Quebec Charter or the Canadian Charter of Rights and Freedoms. On its face, the legislation in Quebec merely restricted the sale of insurance for services that were already covered under a public health insurance scheme. The plaintiffs were not prevented from using their own funds to purchase health care privately, either in Canada or in another country. The restrictions imposed appeared to affect economic rights of the sort not protected in either of the two Charters. The plaintiffs nonetheless argued that the legislation violated their rights to life, liberty, and personal inviolability under the Quebec Charter and their rights to life, liberty, and security of the person under the Canadian Charter.⁹⁵ Despite the somewhat indirect nature of the claims, the justices of the Supreme Court of Canada unanimously supported the view that a prohibition on private insurance could, at least under some circumstances, violate the protected rights of Canadian citizens. The analysis of this issue is inherently interesting, of course, and may have some implications for the United States.

Justice Deschamps in her majority opinion limited her analysis to the provisions of the Quebec Charter, which provides protections for the "right to life, and to personal security, inviolability and freedom."⁹⁶ She found that the ban on private health insurance prevented Quebecers from buying private insurance and that this in turn prevented them from receiving care in the private sector, thereby implicitly finding that insurance is necessary to fund private health care.⁹⁷ The ban on private health insurance therefore forced the plaintiffs to rely solely on the public system to meet their health care needs.⁹⁸ Medical evidence indicating that some people would die

⁹⁵ *Chaoulli*, [2005] 1 S.C.R. at 807.

⁹⁶ *Id.* at 815.

⁹⁷ *Id.* at 818-21.

⁹⁸ *Id.*

while on a waiting list due to delays was sufficient to implicate the right to life.⁹⁹ Medical testimony that waiting for surgery could cause injuries to become irreparable while also causing people to endure pain, limited mobility, and mental suffering was sufficient to show an infringement of personal inviolability.¹⁰⁰ The ban in private health insurance coverage thus forced Quebecers into a public system where rationing, in the form of waiting lists for certain forms of treatment, infringed protected rights to life and to personal inviolability.¹⁰¹

Chief Justice McLachlin and Justice Major (with Justice Bastarache concurring) agreed with Justice Deschamps' analysis of the Quebec Charter. The concurring justices applied a similar analysis and reached the same conclusion under §7 of the Canadian Charter, using much of the same evidence in the trial record. According to Chief Justice McLachlin and Justice Major:

Not every difficulty rises to the level of adverse impact on security of the person under s. 7. The impact, whether psychological or physical, must be serious. However, because patients may be denied timely health care for a condition that is clinically significant to their current and future health, s. 7 protection of security of the person is engaged. Access to a waiting list is not access to health care. As we noted above, there is unchallenged evidence that in some serious cases, patients die as a result of waiting lists for public health care.¹⁰²

The appellants have established that many Quebec residents face delays in treatment that adversely affect their security of the person and that they would not sustain but for the prohibition on medical insurance. It is common ground that the effect of the prohibition on insurance is to

⁹⁹ *Id.* at 819-20 (citing evidence from a cardiovascular surgeon that persons with cardiovascular disease are “‘always sitting on a bomb’ and can die at any moment. In such cases it is inevitable that some patients will die if they have to wait for an operation.”)

¹⁰⁰ *Id.* at 820 (citing evidence from an orthopedic surgeon that “the usual waiting time of one year for patients who require orthopaedic surgery increases the risk that their injuries will become irreparable. . . [and that] many patients on non-urgent waiting lists for orthopaedic surgery are in pain and cannot walk or enjoy any real quality of life.”).

¹⁰¹ *Id.* at 818.

¹⁰² *Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791, 850 (Can.) (McLachlin, C.J., and Major, J., concurring).

allow only the very rich, who do not need insurance, to secure private health care in order to avoid the delays in the public system. Given the ban on insurance, most Quebecers have no choice but to accept delays in the medical system and their adverse physical and psychological consequences.¹⁰³

The concurring justices concluded that “prohibiting health insurance that would permit ordinary Canadians to access health care, in circumstances where the government is failing to deliver health care in a reasonable manner, thereby increasing the risk of complications and death, interferes with life and security of the person as protected by s. 7 of the *Charter*.”¹⁰⁴

The dissenting justices, led by Justices Binnie and LeBel, were more resistant to the conclusion that a ban on private health insurance implicated protected rights. They began their analysis with a discussion of claims that did not involve protected rights. They emphasized that the *Charter* does not protect any “right to contract” grounded in the “liberty” found in §7.¹⁰⁵ The dissent noted that Dr. Chaoulli did not have a protected liberty interest in providing health care outside of the public health care system¹⁰⁶ and rejected as well the notion that individuals have a “constitutional right ‘to spend money.’”¹⁰⁷ The dissenting justices did, however, “accept the trial judge’s finding that the current state of the Quebec health system, linked to the prohibition against health insurance for insured services, is capable, at least in the cases of *some* individuals on *some* occasions, of putting at risk their life or security of the person.”¹⁰⁸ Further, “if the public system fails to deliver life-saving care and an individual is simultaneously prevented from seeking insurance to cover the cost of that care in a private facility, then the individual is potentially caught in a situation that may signal a deprivation

¹⁰³ *Id.* at 845-46.

¹⁰⁴ *Id.* at 850 (McLachlin, C.J., and Major, J., concurring).

¹⁰⁵ *Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791, 879-80 (Can.) (Binnie & LeBel, JJ., dissenting) (“We do not agree with the appellants, however, that the Quebec Health Plan puts the ‘liberty’ of Quebecers at risk. The argument that ‘liberty’ includes freedom of contract (in this case to contract for private medical insurance) is novel in Canada, where economic rights are not included in the Canadian Charter and discredited in the United States.”).

¹⁰⁶ *Id.* at 880.

¹⁰⁷ *Id.* at 880-81.

¹⁰⁸ *Id.* at 875.

of his or her security of the person”¹⁰⁹ if the intrusion into physical or mental security is sufficiently serious.¹¹⁰

It appears that the justices of the Supreme Court of Canada were willing to recognize that private health insurance is the *sine qua non* of access to health care in a private market place. Without access to private health insurance, citizens were forced into a public system that admittedly rationed care by using waiting lists for certain types of treatments. The justices unanimously found that a restriction on the private market for health insurance could, in these circumstances, cause the deprivation of the right to life and security of the person. In the next section, we will explore the court’s analysis of whether the needs of the public health care system justified the infringement of protected individual rights.

D. ARE BANS ON PRIVATE HEALTH INSURANCE RATIONALLY RELATED TO THE MAINTENANCE OF A PUBLIC HEALTH CARE SYSTEM?

In *Chaoulli*, the justices of the Supreme Court of Canada all agreed that the maintenance of the publicly funded health care system was a legitimate and likely even a “pressing and substantial” governmental objective.¹¹¹ The key question then became whether the ban on private health insurance

¹⁰⁹ *Id.* at 880-81.

¹¹⁰ *Id.* at 881-82.

¹¹¹ See *R. v. Oakes*, [1986] 1 S.C.R. 103, 138-40 (Can.) (setting out the proper analysis for claims under §1 of the Canadian Charter of Rights and Freedoms). Justice Deschamps applied this test in applying the justificatory provisions of §9.1 of the Quebec Charter, finding that: “the purpose of the prohibition is to preserve the integrity of the public health care system. From this perspective, the objective appears . . . [and is later confirmed] to be pressing and substantial.” *Chaoulli*, [2005] 1 S.C.R. 791, 825-26 (Deschamps, J.). The Chief Justice and Justice Major accepted that “the government undeniably has an interest in protecting the public health regime” as part of their §1 analysis under the Canadian Charter. *Id.* at 859 (McLachlin, C.J., and Major, J., concurring). The dissenting justices also considered the purpose of the prohibition on private health insurance coverage in their §1 analysis. The dissent found that:

Quebec’s legislative objective is to provide high quality health care, at a reasonable cost, for as many people as possible in a manner that is consistent with principles of efficiency, equity and fiscal responsibility. Quebec . . . subscribes to the policy objectives of the *Canada Health Act* The legislative task is to strike a balance among competing interests. . . . The appellants do not challenge the constitutional validity of the objectives set out in the *Canada Health Act*.

Id. at 896-97 (Binnie & LeBel, JJ., dissenting).

coverage was sufficiently related to the goal of preserving the public health care system. The justices diverged sharply on the question of whether the provincial ban on private health insurance was justified under §9.1 of the Quebec Charter, the “principles of fundamental justice” portion of §7 of the Canadian Charter, or the justificatory provisions of §1 of the Canadian Charter. Although these three provisions use different language and, at least in part, different analytical frameworks,¹¹² the justices’ three opinions in the end depended on whether or not the prohibition of private health insurance was sufficiently related to and necessary for the maintenance of a strong public health care system.

The four justices who ultimately invalidated Quebec’s ban in private health insurance relied on four key arguments. First, they noted that the Canada Health Act does not prohibit the development of a private health insurance or private care.¹¹³ The provinces themselves vary, with only a few banning the sale of private health insurance for covered services.¹¹⁴ The lack of uniform legislative response to the prospect of a private market undercut the argument that a ban on private insurance or private care was necessary to maintain the system.

Second, the majority found no direct and conclusive evidence in the record that the development of a market for private health insurance market and the potential expansion of a private health care system would actually undermine the public health care system. The government presented witnesses who testified that (a) “the emergence of the private sector would lead to a reduction in popular support . . . for the public plan”;¹¹⁵ (b) “the most influential people would no longer have any incentive to bring pressure for improvements to the [public plan] because they would obtain better coverage privately¹¹⁶; (c) “there would be a reduction in human resources in the public plan because many physicians and health care professionals would leave the plan out of a motive for profit”¹¹⁷; and (d)

¹¹² See *supra*, text accompanying notes 80-83, 91-92.

¹¹³ *Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791, 844 (Can.) (McLachlin, C.J., and Major, J., concurring).

¹¹⁴ As noted by Justice Deschamps, “The approach to the role of the private sector taken by the other nine provinces of Canada is by no means uniform. In addition to Quebec, six other provinces have adopted measures to discourage people from turning to the private sector. The other three, in practice, give their residents free access to the private sector.” *Chaoulli*, [2005] 1 S.C.R. 791 at 831 (Deschamps, J.). See also *id.* at 831-32 (summarizing relevant provincial legislation in each jurisdiction).

¹¹⁵ *Chaoulli*, [2005] 1 S.C.R. 791, 828 (Deschamps, J.).

¹¹⁶ *Id.*

¹¹⁷ *Id.*

the development of a private health care market would “lead to a decline in the professionalism and ethics of physicians.”¹¹⁸ Justice Deschamps characterized this evidence as being based on “logic or common sense” that was subject to dispute; she emphasized the absence of research studies or empirical evidence.¹¹⁹

The government also contended that the private market would negatively impact the public plan by (a) increasing overall health expenditures¹²⁰; (b) allowing private insurers to “reject the most acute patients, leaving the most serious cases to be covered by the public plan”¹²¹; and (c) encouraging physicians “to lengthen waiting times in the public sector in order to direct patients to the private sector.”¹²² Justice Deschamps once again discounted these claims, noting among other things that the cost increases would be born by private individuals, that the public system would not be worse off if left with seriously ill patients for whom they already provided care, and that conflicts of interest could be and were being managed in other ways.¹²³

Chief Justice McLachlin and Justice Major conducted a similar analysis and reached a similar result in their concurring opinion, though using the framework of “arbitrariness” under §7’s analysis of the principles of fundamental justice.¹²⁴ After summarizing the government’s evidence about the relationship between the ban on private health insurance coverage and the need to maintain the public health care system, these justices found that “[t]o this point, we are confronted with competing but unproven ‘common sense’ arguments, amounting to little more than assertions of belief. We are in the realm of theory. But as discussed above, a theoretically defensible limitation may be arbitrary if in fact the limit lacks a connection to the goal.”¹²⁵ For the *Chaoulli*’s majority and concurring justices the next best place to look for evidence of a connection between the ban and the public system was in the experience of other countries.

¹¹⁸ *Id.* at 829.

¹¹⁹ *Id.*

¹²⁰ *Chaoulli*, [2005] 1 S.C.R. 791, 829 (Deschamps, J.).

¹²¹ *Id.* at 830.

¹²² *Id.*

¹²³ *Id.*

¹²⁴ *Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791, 853 (Can.) (McLachlin, C.J., and Major, J., concurring). (“interference with life, liberty and security of the person is impermissibly arbitrary if the interference lacks a real connection on the facts to the purpose the interference is said to serve”).

¹²⁵ *Id.* at 854 (McLachlin, C.J., and Major, J., concurring).

Justice Deschamps and Chief Justice McLachlin and Justice Major reviewed the experiences of other OECD countries.¹²⁶ The absolute prohibition of private insurance for health care delivered by physicians who are not participating in the public system is unique to some provinces in Canada.¹²⁷ The majority and concurring opinions noted that many OECD countries with strong public health systems permit private health insurance and have developed a strong private market for health care. For these justices, the evidence thus tilted toward the conclusion that the ban on private health insurance was not sufficiently related to the goal of preserving the public health care system. Thus Chief Justice McLachlin and Justice Major's concurring opinion notes: "This brings us to the evidence called by the appellants at trial on the experience of other developed countries with public health care systems which permit access to private health care. The experience of these countries suggests that there is no real connection in fact between prohibition of health insurance and the goal of a quality public health system."¹²⁸

Fourth and finally, the majority and concurring opinions rejected claims that the courts should defer to legislative judgment in this sensitive and important public policy debate. The courts were not required to defer to the legislative branch. Justice Deschamps noted:

The instant case is a good example of a case in which the courts have all the necessary tools to evaluate the government's measure. Ample evidence was presented. The government had plenty of time to act. Numerous commissions have been established. . . . Governments have promised on numerous occasions to find a solution to the problem of waiting lists. . . [I]t seems that governments have lost sight of the urgency of taking concrete action. The courts are therefore the last line of defence for citizens.¹²⁹

Similarly, the Chief Justice and Justice Major rejected the call for judicial deference: "The fact that the matter is complex, contentious or

¹²⁶ See, e.g., *id.* at 833-36 (Deschamps, J.) and 855-58 (McLachlin, C.J., and Major, J., concurring).

¹²⁷ *Id.* at 833-34 (Deschamps, J.).

¹²⁸ *Id.* at 854 (McLachlin, C.J., and Major, J., concurring).

¹²⁹ *Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791, 853, 840 (Can.) (Deschamps, J.).

laden with social values does not mean that the courts can abdicate the responsibility vested in them by our Constitution to review legislation for *Charter* compliance when citizens challenge it.”¹³⁰ For Chief Justice McLachlin and Justice Major, the court’s review was narrow in scope: “[t]he *Charter* does not confer a freestanding constitutional right to health care. However, where the government puts in place a scheme to provide health care, that scheme must comply with the *Charter*.”¹³¹

This Essay’s discussion of *Chaoulli* has not focused on the intricacies of Canadian constitutional law, the details of the legal analyses employed by the justices, or on the strengths and weaknesses of their use of precedent. Given the limited discussion of these important issues, the majority and concurring opinions seem straightforward, logical, and even compelling. Yet it is important to recognize that the *Chaoulli* decision included a very strong dissent and that there are many critics of the majority and concurring opinions.¹³²

One important critique focuses on the standards for determining whether §7 rights have been infringed. The dissent was sharply critical of the “test” for when restrictions on the private market will implicate the rights protected by §7 of the Canadian Charter. The Chief Justice and Justice Major had noted in their concurring opinion that “[b]y imposing exclusivity and then failing to provide public health care of a reasonable standard within a reasonable time, the government creates circumstances that trigger the application of s.7.”¹³³ The dissent argued that this appeared to be a legal rule but that it was at best a policy formula with no settled answer:

What, then, are constitutionally required “reasonable health services”? What is treatment “within a reasonable time”? What are the benchmarks? How short a waiting list is short enough? How many MRIs does the Constitution require? The majority does not tell us. The majority lays down no manageable constitutional standard. The public cannot know, nor can judges or governments know, how much health care is “reasonable”

¹³⁰ *Id.* at 844 (McLachlin, C.J., and Major, J., concurring).

¹³¹ *Id.* at 843 (McLachlin, C.J., and Major, J., concurring).

¹³² See, e.g., ACCESS TO CARE, *supra* note 94; Symposium on *Chaoulli*, *supra* note 94.

¹³³ *Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791, 853, 861-62 (Can.) (Binnie & LeBel, JJ., dissenting).

¹³³ *Id.* at 843-44 (McLachlin, C.J., and Major, J., concurring).

enough to satisfy [the Canadian Charter]. . . It is to be hoped that we will know it when we see it.¹³⁴

These concerns are amplified by the dissent's view that rationing is inevitable in any health care system, whether public, private or mixed, and that there is no meaningful consensus about appropriate waiting times.¹³⁵ For these reasons, and others, the dissent argued that the Supreme Court of Canada should have deferred to the legislative choice to bolster the public health system by restricting access to the private market.¹³⁶

In addition, many have argued that the majority and concurring opinions' review of the evidence presented at trial and available in previous studies is somewhat selective. Thus, while citing the data in the Romanow and Kirby Reports, the majority and concurring opinions fail to note that these reports and virtually all others in Canada have confirmed the need to prevent the emergence of a private health care market that could create a "two-tier" system of medicine in Canada.¹³⁷ Justices Binnie and LeBel noted that "[t]he Quebec government views the prohibition against private insurance as essential to preventing the current single-tier system from disintegrating into a *de facto* two-tier system. The trial judge found, and the evidence demonstrated, that there is good reason for this fear."¹³⁸ Justices Binnie and LeBel argued vehemently that the trial judge had sufficient evidence – more than common sense conjecture – to find that the ban on private health insurance protected the integrity of the public health system.¹³⁹

E. THE AFTERMATH

The *Chaoulli* case was ultimately decided on a narrow basis, under the Quebec Charter, rather than under the Canadian Charter of Rights and Freedoms.¹⁴⁰ It nonetheless created considerable controversy and widespread concern that the decision would upset the foundations of the

¹³⁴ *Id.* at 861-62 (Binnie & LeBel, JJ., dissenting).

¹³⁵ *Id.* at 883-85.

¹³⁶ *Id.* at 860-61.

¹³⁷ *Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791, 853, 893-94 (Can.) (Binnie & LeBel, JJ., dissenting).

¹³⁸ *Id.* at 863.

¹³⁹ *Id.* at 885-86.

¹⁴⁰ *See supra*, text accompanying notes 91-93.

Canadian health care system.¹⁴¹ Four years later, little has changed across Canada.

Quebec adopted legislation in December 2006.¹⁴² Under Bill 33, the province established centralized public waiting lists for various procedures and expressed a commitment to reducing waiting times.¹⁴³ The legislation also authorized the creation of private hospitals; one type of private hospital could contract to provide services for the public system and another would be purely private, staffed by physicians who have “opted out” of the public system. These private facilities would be limited to providing certain types of services in order to reduce the waiting time for access to those services.

No other province has significantly altered its approach to private health care. Alberta’s then-premier initially praised the *Chaoulli* decision and vowed to loosen constraints on the private health care system. After much fanfare and anticipation, Alberta abandoned these “Third Way” proposals when the public proved unenthusiastic about the reforms.¹⁴⁴

Chaoulli’s more lasting legacy appears to be in focusing political and public attention on waiting lists and the reduction of wait times.¹⁴⁵ *Chaoulli* helped to accelerate federal and provincial efforts to reduce waiting times for a number of important procedures, such as hip replacements or cataract surgery.¹⁴⁶ Private health care continues to be controversial and subject to significant legal constraints.¹⁴⁷

¹⁴¹ See, e.g., Lawrie McFarlane, *Supreme Court slaps for-sale sign on medicare*, 173 CMAJ 269 (2005). See generally ACCESS TO CARE, *supra* note 94; Symposium on *Chaoulli*, *supra* note 94.

¹⁴² An Act to Amend the Act respecting health services and other social services and other legislative provisions, Bill 33 (2006, Chapter 43), Quebec National Assembly, 37th Legislature, 2nd Session (December 2006), <http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=5&file=2006C43A.PDF>.

¹⁴³ See, e.g., John Geddes, *Waiting for a Revolution*, MACLEANS, Dec. 30, 2007, http://www.macleans.ca/science/health/article.jsp?content=20071219_74840_74840 (“Last year, Premier Jean Charest’s government satisfied the court’s requirements by promising to provide joint replacements and cataract surgery within six months of a doctor determining a patient needs the surgery. If government-funded hospitals can’t do the job, the government will pay to have it done at a private clinic. As well, the Charest government moved to let Quebecers pay privately for a limited range of services, but predicted few would, since the public system was about to get considerably faster”).

¹⁴⁴ See Wayne Kondro, *Take the Highway*, 179 CMAJ 25 (2008).

¹⁴⁵ Geddes, *supra* note 143.

¹⁴⁶ *Id.*

¹⁴⁷ See, e.g., Petti Fong, *Private B.C. Clinic Reopens to Public*, THE TORONTO STAR, April 10, 2007, at A11.

V. CONCLUSIONS AND LESSONS FOR THE U.S.

I argue in this Essay that it is important to take a limited, skeptical view of cross-border health policy arguments. Canada is significantly different from the U.S. in many respects, including in its commitment to health care as a public good and its concerns about market-based allocations of health insurance or health care. We need to be cautious when looking to Canada to ensure that we are not merely gazing at a reflection of our own hopes or anxieties. With this cautionary reminder, this Essay's analysis has suggested several important observations about the health insurance debate in the United States.

Lesson 1: Look East or West rather than North or South

The data on cost, access, and health care outcomes suggests that both Canada and the United States should look to other countries for ideas about the organization and delivery of health care. While Canadians enjoy better health care at lower costs and with better outcomes than citizens of the United States, the health care systems of both countries suffer in comparison to other OECD countries.¹⁴⁸ In *Chaoulli*, the majority and concurring justices avoided citing the United States experience, relying instead the role of private health care of other OECD countries in Europe, Japan, and Australia.¹⁴⁹ Justice Deschamps, Chief Justice McLachlin and Justice Major therefore undoubtedly sought to avoid both the ideological baggage and poor results of the United States' system. Advocates for health care reform in the U.S. might well follow this example and focus attention on other OECD countries.

Lesson 2: Courts Sometimes Resist Ideological Constraints

Canada and the U.S. are commonly distinguished by fundamentally different views about whether health care is an ordinary market commodity or a special social good. Peter P. Budetti has characterized the debate as between "market justice" and "social justice."¹⁵⁰ In the U.S., where the market justice "runs deeply," "[i]ndividual resources and choices determine

¹⁴⁸ See *supra*, text accompanying notes 26-68.

¹⁴⁹ See *Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791, 833-36 (Can.) (Deschamps, J.); *id.* at 854 (McLachlin, C.J., and Major, J., concurring).

¹⁵⁰ Peter P. Budetti, *Market Justice and US Health Care*, 299 JAMA 92 (2008).

the distribution of health care, with little sense of collective obligation or a role for government.”¹⁵¹ In Canada, the social justice view dominates: the view that “goods and services [are allocated] according to the individual’s needs... stems from principles of shared responsibility and concern for the communal well-being with government as the vehicle for ensuring social equity.”¹⁵² Courts sometimes act as a counterweight to these ideological commitments.

The *Chaoulli* decision is an example of this phenomenon. Quebec sought to justify its restriction on private health insurance as necessary to preserve the social justice basis of the public health care system. The government argued that private insurance would at minimum result in some individuals having better access to care than others based on their ability to pay and that it might, in addition, erode the social justice underpinnings of the public system.¹⁵³ A majority of the justices rejected this argument, finding that the government prohibition unreasonably risked the lives and health of individual Quebecers.¹⁵⁴ The justices expressed concerns that the prohibition on private coverage was based on ideology rather than evidence.¹⁵⁵ In the end, the Supreme Court of Canada therefore actually supported the expansion of the private market for health insurance in Canada despite the social justice ideology prevalent in that country.

The recent en banc decision of the United States Court of Appeals for the District of Columbia in *Abigail Alliance v. Eschenbach* provides a parallel example from the United States.¹⁵⁶ In *Abigail Alliance*, plaintiffs challenged an FDA policy which prohibited manufacturers from selling certain experimental drugs to terminally ill patients.¹⁵⁷ The plaintiffs’ claims mirrored those asserted in *Chaoulli*: they argued that the federal rule had the effect of denying them access to potentially life-saving or life-extending treatment and therefore violated their fundamental right to self-preservation. As in *Chaoulli*, the market prohibition was justified, in part,

¹⁵¹ *Id.* at 92.

¹⁵² *Id.* Burdetti contends that “Social justice in health care requires universal coverage and ensured access to care, whether through social insurance, private insurance, or some combination.” *Id.*

¹⁵³ *See supra*, note 120-22.

¹⁵⁴ *See supra*, text accompanying notes 111-31.

¹⁵⁵ *See supra*, text accompanying notes 119 & 125. Justice Deschamps noted that the courts were the last line of the defense for individuals when the government failed to act. *See supra*, text accompanying note 129.

¹⁵⁶ *Abigail Alliance v. Eschenbach*, 495 F.3d 695 (D.C. Cir. 2007), *cert. denied* 128 S. Ct. 1069.

¹⁵⁷ *Abigail Alliance*, 495 F.3d at 697.

by the needs of the public: it was feared that giving terminally ill persons access to experimental therapies outside of clinical trials would compromise the integrity of the clinical trial system.¹⁵⁸ A panel decision favoring the plaintiffs was withdrawn and replaced by an en banc decision rejecting the claim that the market restriction implicated any fundamental right.¹⁵⁹ The United States Supreme Court denied certiorari.¹⁶⁰ In the end, the U.S. courts favored restricting the private market for experimental therapies, at least in part to preserve the public good.

Lesson 3: Ideological Commitments Nonetheless Substantially Constrain Health Care Reform

Canadians and Americans share a deep ideological commitment to the fundamental premises of their health care systems even as those premises are under considerable pressure. Canadians are deeply attached to the vision of health care as a public good allocated based on need rather than wealth, even as health care expenditures place increasing pressure on governmental budgets. Moreover, limits to the benefits provided under the Canadian Medicare program mean that 30% of health expenditures are paid by individuals or private health insurance.¹⁶¹ Yet the specter of private health care is considered to be a threat rather than either a present reality or as a viable option for addressing the growing constraints on the public health care system.

In some ways, Americans are even more constrained by ideological commitments. American rejection of “socialized medicine” or to government-run health care appears to ignore the realities of the health care market place in the U.S., in which 40% of the direct expenditures are made by governmental entities and even the employment-based “private” health

¹⁵⁸ See, e.g., Peter D. Jacobson and Wendy E. Parmet, *A New Era of Unapproved Drugs*, 297 JAMA 205 (2007) (noting possible impact on clinical trials). *Chaoulli* and *Abigail Alliance* are not precisely analogous because *Abigail Alliance* involved a much greater uncertainty about whether permitting a patient to access the private market would actually protect that patient’s health or life. That is, it seemed probable that giving patients access to certain medical treatments in a private market would preserve and extend life but it is not nearly as clear that giving terminally ill patients access to unapproved drug therapies would actually preserve life.

¹⁵⁹ *Abigail Alliance*, 495 F.3d at 711.

¹⁶⁰ *Abigail Alliance v. Eschenbach*, 128 S. Ct. 1069.

¹⁶¹ See *supra*, text accompanying note 27.

insurance market is subsidized by substantial federal tax breaks.¹⁶² Policy debates in the U.S. are characterized by significant ideological -- and political -- commitments to preserving both the private health insurance market and the image of U.S. health care as primarily a private system with narrow public responsibility and involvement. President Bush's veto of the expansion of the Children's Health Insurance Program in 2008 was directly linked to the threat that the public program would draw enrollment away from the private health insurance market.¹⁶³

Health care reform efforts in both the United States and Canada therefore must meet ideological litmus tests, perhaps because both systems are close to a transformative "tipping point." In both countries, significant reforms seem unlikely, despite relatively poor performance and high levels of public concern.¹⁶⁴ It sometimes seems that the primary purpose of policy comparisons between Canada and the U.S. is to assure citizens that no matter how concerned they are about their own health care system, they can at least be grateful that they do not have the other country's system. Thus Canadians react just as negatively to the specter of a two-tiered health care system as Americans do to the threat of Canada's erroneously-labeled system of "socialized medicine." There is no fork in the road when it comes to health care reform because one path is blocked by ideological constraints. Even within the single permissible path, health care reform proposals are evaluated in part by whether they will create a side route away from the ideological commitments of each system.

¹⁶² See *supra*, text accompanying notes 30; Paul Fronstein and Dallas Salisbury, *Health Insurance and Taxes: Can Changing the Tax Treatment of Health Insurance Fix Our Health Care System?*, EMP. BENEFIT RES. INST. ISSUE BRIEF NO. 309, Sept. 2007, 1-25, http://www.ebri.org/pdf/briefspdf/EBRI_IB_09-20074.pdf; Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2007 Current Population Survey*, 2007 EMP. BENEFIT RES. INST. ISSUE BRIEF NO. 310, Oct. 2007, http://www.ebri.org/pdf/briefspdf/EBRI_IB_10-20073.pdf.

¹⁶³ Robert Pear, *Veto Stands on Measure to Expand Health Plan*, N.Y. TIMES, Jan. 24, 2008, at A18.

¹⁶⁴ For a discussion of public concerns about health care in the U.S., Canada, and other countries, see Cathy Schoen, et al., *Higher-Performance*, *supra* note 36, at w717, w721 (Exhibit 2). Seventy-two percent of Canadians surveyed and 82% of Americans surveyed thought their health systems needed fundamental changes or to be rebuilt completely. *Id.* Twenty-six percent of Canadians and 16% of Americans thought their health care systems worked well with only minor changes needed.

Lesson 4: The Cross-Border Trade in Health Law is Underdeveloped

The high level of cross-border policy debate between Canada and the United States can sometimes obscure the relative lack of interest in cross-border health law. In some senses this should not be surprising: law is after all a peculiarly national and local phenomenon. Legislation applies only within the legislature's jurisdictional boundaries. Courts rely on precedents, most often from their own jurisdictions, and have only a limited authority to consider the legislation and judicial decisions of other countries. U.S. courts rarely cite the precedents of other jurisdictions as a basis for their own decisions and face considerable controversy when they do so.¹⁶⁵

Yet this Essay has suggested some areas in which health law academics and perhaps even health care advocates might profitably consider additional consultation and collaboration. The *Chaoulli* decision includes two areas of possible mutual interest: (a) a substantive exploration of when, if ever, restrictions on a private market can be considered to intrude on individual liberty; and (b) a process-oriented analysis of the role of courts in addressing the problems of a health care system in the face of legislative inaction.

Scholars thus might reasonably consider the close parallels between the Supreme Court of Canada's decision in *Chaoulli* and the D.C. Court of Appeals decision in *Abigail Alliance*. The courts in these two cases struggled to define when and how restrictions on the creation of a private market impermissibly infringed individual life and liberty. It is at least interesting that the Supreme Court of Canada was more willing to accept such a claim than the D.C. Court of Appeals. There may well be aspects of the arguments or opinions in *Chaoulli* that might be used in presenting future claims in the U.S. The "self-preservation" argument made in *Abigail Alliance* might be more compelling, for example, in cases where the restriction on the market creates more definite harm for the individual and

¹⁶⁵ See, e.g., Mark C. Rahdert, Comparative Constitutional Advocacy, 56 AMER. U. L. REV. 553 (2007) (noting controversy in the U.S. Supreme Court regarding use of foreign precedent). Canadian courts are more comfortable with the use of foreign precedent, in part because of the shared legal heritage of commonwealth countries and in part because of the relatively small number of Canadian judicial decisions. Cf. Myra J. Tawfik, *No Longer Living in Splendid Isolation: The Globalization of National Courts and the Internationalization of Intellectual Property Law*, 32 QUEEN'S L.J. 573 (2007) (noting "transjudicialism" on constitutional law and human rights cases, analyzing similar trend in Canadian IP jurisprudence).

where the collective interest market restrictions is based on ideology rather than demonstrated necessity.¹⁶⁶ Similarly, Canadian scholars and advocates might consider whether the *Chaoulli* decision means that the Canadian courts will be more receptive to other types of challenges to market restrictions, such as those governing experimental therapies or organ transplantation. The *Chaoulli* case also provides an interesting case study in the ability of courts to analyze and digest health policy and health policy research as well as in the role of courts in fostering health care reform.

Despite these linkages, as of November 2008, no reported decisions in Canada have cited the *Abigail Alliance* litigation and only one U.S. court has referred to the *Chaoulli* case.¹⁶⁷ Thirty-eight articles in U.S. journals found in the Westlaw JLR database referred to *Chaoulli* while no articles in the Canada-JLR database referred to *Abigail Alliance*.¹⁶⁸ The cross-border trade in health law theories and arguments may therefore have considerable room to grow in the years ahead.

¹⁶⁶ For an influential discussion of the self-defense argument, see Eugene Volokh, *Medical Self-Defense, Prohibited Experimental Therapies, and Payment for Organs*, 120 HARV. L. REV. 1813 (2007).

¹⁶⁷ Westlaw search performed in the “allcases” (U.S.) and “can-allcases” (Canada) databases (search performed November 30, 2008).

¹⁶⁸ Westlaw search performed November 30, 2008. For one particularly insightful comparative analysis, see, e.g., Roy G. Spece, Jr., *A Fundamental Constitutional Right of the Monied to “Buy Out of” Universal Health Care Program Restrictions Versus the Moral Claim of Everyone Else to Decent Health Care: An Unremitting Paradox of Health Care Reform?*, 3 J. HEALTH & BIOMEDICAL L. 1 (2007).

IS HEALTH INSURANCE A BAD IDEA? THE CONSUMER-DRIVEN PERSPECTIVE

Timothy Stoltzfus Jost¹

Unique among the developed nations of the world, the United States depends on private insurance to insure a majority of its residents.² Private insurance exists virtually everywhere in the world, but in most countries it merely supplements or complements a comprehensive public insurance program that covers all, or virtually all, of the population.³ There are complicated historical, political, and cultural reasons why we depend on private insurance for health coverage in the United States.⁴ It seems very unlikely, however, that we will abandon private health insurance as our primary form of health coverage in the foreseeable future.

Nevertheless, it seems clear, that private insurance coverage in the United States is on the decline. Employment-based insurance coverage probably peaked sometime in the late 1970s or early 1980s, and has been falling ever since, with a brief uptick in the late 1990s. Coverage has dropped from 73 percent of the population under 65 in 1999 to 66.5 percent in 2006.⁵ Even though public insurance coverage has been growing as private insurance coverage shrinks, the number of uninsured continues to rise, to 43.6 to 44.8 million, nearly 17% of the under-65 population in 2005-2006.⁶

1. Robert F. Willett Family Professor, Washington and Lee University., This article was submitted in August of 2007, and was current as of that date. It is based in part on my recently published book: TIMOTHY STOLTZFUS JOST, *HEALTH CARE AT RISK: A CRITIQUE OF THE CONSUMER-DRIVEN MOVEMENT* 54-69 (2007). I would like to thank the Frances Lewis Law Center and the Willett Family for research support.

2. See Timothy Stoltzfus Jost, *Why Can't We Do What They Do? National Health Reform Abroad*, 32 J.L. MED. & ETHICS 433, 433 (2004) (describing how other nations provide health care coverage).

3. ELIAS MOSSIALOS & SARAH M.S. THOMPSON, *VOLUNTARY HEALTH INSURANCE IN THE EUROPEAN UNION, FUNDING HEALTH CARE: OPTIONS FOR EUROPE* 128-31 (Elias Mossialos et al. eds., 2002)

4. See JOST, *HEALTH CARE AT RISK*, *supra* note 1.

5. CENTER FOR DISEASE CONTROL AND PREVENTION, *PERCENTAGE OF PERSONS UNDER AGE 65 YEARS WITH PUBLIC HEALTH PLAN COVERAGE AND PRIVATE HEALTH INSURANCE COVERAGE, BY AGE GROUP: UNITED STATES, 1997-2006* (2007), http://www.cdc.gov/nchs/data/nhis/earlyrelease/200706_01.pdf.

6. The lower figure is from: CENTER FOR DISEASE CONTROL AND PREVENTION, *NUMBER AND PERCENTAGE OF PERSONS WITHOUT HEALTH INSURANCE COVERAGE AT THE TIME OF INTERVIEW, BY AGE GROUP: UNITED STATES, 1997-2006* (2007),

Although most view the number of uninsured as a problem, a small, but very influential minority of American policy advocates consider “overinsurance” to be our most serious policy problem.⁷ The strength of this movement, known euphemistically as the consumer-driven health care (CDHC) movement, is demonstrated by the fact that these advocates succeeded in the waning moments of the 109th Congress, in expanding federal tax subsidies for health savings accounts (HSAs), their policy alternative to conventional health insurance.⁸

Since the early 1970s, a number of conservative and libertarian advocacy groups have kept up a steady drumbeat of criticism of our current private health insurance system.⁹ They claim that this system is the product of bad public policy, in particular of the employment-related health insurance tax subsidy.¹⁰ This subsidy, they charge, has resulted in employers offering and employees accepting far more insurance than would be purchased without the tax subsidy.¹¹

This excessive insurance, they claim, results in excess consumption and higher prices of health care. The tax subsidy decreases the price to consumers and thus increases the demand for health insurance, which in turn decreases the price to consumers and increases the demand for health

http://www.cdc.gov/nchs/data/nhis/earlyrelease/200706_01.pdf. The higher figure is from: Press Release, U.S. Census Bureau, Census Bureau Revises 2004 and 2005 Health Insurance Coverage Estimates (Mar. 23, 2007), *available at* http://www.census.gov/Press-Release/www/releases/archives/health_insurance/009789.html.

7. See MICHAEL F. CANNON & MICHAEL D. TANNER, *HEALTHY COMPETITION: WHAT’S HOLDING BACK HEALTH CARE AND HOW TO FREE IT* 46-58 (2005); JOHN C. GOODMAN, GERALD L. MUSGRAVE & DEVON M. HERRICK, *LIVES AT RISK: SINGLE-PAYER NATIONAL HEALTH INSURANCE AROUND THE WORLD* 4 (2004); JOST, *supra* note 1, at 35.

8. Health Savings Accounts were created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1201, 117 Stat. 2066 (2003), and codified at I.R.C. § 223 (2007). Contribution limits were liberalized by the Health Opportunity Patient Empowerment Act of 2006 in the last minutes of the 109th Congress; see Press Release, United States Treasury, President Bush Signs Bill to Make Health Care More Affordable, Accessible (Dec. 20, 2006), *available at* <http://www.ustreas.gov/press/releases/hp209.htm>.

9. See JOST, *HEALTH CARE AT RISK*, *supra* note 1, at 70-85.

10. See JOHN F. COGAN, R. GLENN HUBBARD & DANIEL P. KESSLER, *HEALTHY, WEALTHY, AND WISE: FIVE STEPS TO A BETTER HEALTH CARE SYSTEM*, 15-16, 27-33 (2005); CANNON & TANNER, *supra* note 7, at 61-66; JOHN C. GOODMAN, GERALD L. MUSGRAVE & DEVON M. HERRICK, *PATIENT POWER: SOLVING AMERICA’S HEALTH CARE CRISIS*, 50-51 (1992).

11. CANNON & TANNER, *supra* note 7, at 62-65.

care.¹² Insured health care consumers buy far more health care products and services than they would if they had to pay for health care out of their own pockets. This is the phenomenon of moral hazard that insurance teachers talk about every day. Consumers also pay higher prices than they would pay without insurance because they have no incentive to shop around for lower price providers.¹³ The tax subsidy is, therefore, one of the most important reasons why health care costs so much in the United States.¹⁴ While the moral hazard claims of CDHC advocates seem to be solidly based in neoclassical economic theory, they also are supported by the Rand Health Insurance Experiment, which found that insureds with higher deductible plans do in fact consume less health care.¹⁵

But there is more to their claims. CDHC advocates also argue that consumers who are not paying for health care out of their own pockets are less concerned about quality than they might be if they were paying for services themselves.¹⁶ At least, consumers have less reason to seek out comparative information regarding providers, which could support shopping based on quality as well as cost.¹⁷ Fully insured individuals also have less incentive to take care of themselves, to engage in healthy behaviors and seek preventive or early primary care, and thus are more likely to become ill and need health care¹⁸ (a claim, by the way, that the Rand study found no evidence to support).¹⁹

The ultimate solution to the problem of excess insurance—simply outlawing health insurance—is not embraced by even the most fervent market advocates. They understand the problem of catastrophic costs – of the highly skewed nature of health care costs that accounts for health insurance in the first place.²⁰ Few people can afford to pay out of pocket for a heart transplant or for the services required to respond to the major

12. CANNON & TANNER, *supra* note 7, at 62-63; COGAN, HUBBARD & KESSLER, *supra* note 10, at 29-30.

13. JOST, *supra* note 1, at 19.

14. *See supra* note 10.

15. *See* JOSEPH P. NEWHOUSE, FREE FOR ALL? LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT (1993); *see* JOST, *supra* note 1, at 120-28 (examining the findings of and critiquing the RAND HIE).

16. CANNON & TANNER, *supra* note 7, at 54-57.

17. *Id.*

18. GOODMAN et al., *supra* note 10, at 92-94.

19. NEWHOUSE, *supra* note 15 at 200-01, 208.

20. *See* Jost, *Why Can't We Do What They Do?*, *supra* note 2, at 436.

traumatic injuries caused by a car accident.²¹ Many of those afflicted with expensive chronic diseases would soon find themselves unable to afford further health care without health insurance. Bankruptcy solves the problems of some of those faced with enormous expenses and no insurance, but it only deals with already incurred costs and does not assure continuing access to care.²² Bankruptcy, moreover, only shifts the costs of care to providers, who themselves may be financially unable to absorb the loss.

Acknowledging the problems that would attend the elimination of health insurance, CDHC advocates rather call for limiting insurance to truly catastrophic expenses through the imposition of high deductibles.²³ Most, but not all, CDHC advocates also call for the creation of health savings accounts (HSAs) to be coupled with high-deductible health insurance plans (HDHPs).²⁴ They call for tax subsidies to cover contributions to the HSAs (whether contributions come from employers or employees) as well as the income from those plans and payments for high-deductible health plans.²⁵ Advocates contend that HSAs will introduce point-of-purchase competition into health care and save the cost of claims processing, thus reducing health care costs.²⁶ At the same time, they believe that HSAs will assure that consumers have funds available to purchase health care, thus assuring access, and will encourage consumers to shop for better quality products and services, thus improving quality. They even argue that moving to CDHC will expand insurance coverage, as catastrophic policies will be more affordable, both because they offer thinner coverage and because consumers will consume more cost consciously, bringing down insurance costs.²⁷

Over the past half decade the CDHC movement has been extraordinarily successful in public policy advocacy. Although tax subsidies for medical savings accounts were first introduced by the Health Insurance Portability and Accountability Act of 1996, they were subject to

21. According to recent estimates, heart transplants cost from \$50,000 to \$287,000, averaging \$148,000, while liver transplants cost from \$66,000 to \$367,000, averaging \$235,000. *Transplant*, CHFPATIENTS.COM, <http://www.chfpatients.com/tx/transplant.htm>.

22. See Melissa B. Jacoby, *The Debtor Patient: In Search of Non-Debt Based Alternatives*, 69 BROOK. L. REV. 453, 456-57, 462 (2003-2004).

23. GOODMAN et al., *supra* note 10, at 231-32.

24. *Id.*, CANNON & TANNER, *supra* note 7, at 66-68.

25. CANNON & TANNER, *supra* note 7, at 67; Cogan, Hubbard, & Kessler, *supra* note 10, at 35-38.

26. GOODMAN et al., *supra* note 10, at 249-250.

27. *Id.* at 250.

many restrictions and never really caught on.²⁸ The Medicare Modernization Act of 2003 (“MMA”), however, greatly expanded tax subsidies for health care accounts, which it rechristened health savings accounts, or HSAs.²⁹

The MMA offers a tax exclusion to employers and a deduction to employees for funds contributed by an employer or employee to an HSA. The HSA must, however, be coupled with a HDHP, which must, in 2007, have a deductible of at least \$1100 a year for a single individual or \$2200 a year for family coverage.³⁰ The catastrophic policies that accompany an HSA must also have caps on out of pocket expenditures, which cannot exceed \$5500 for an individual and \$11,000 for a family in 2007.³¹ The tax subsidies for contributions to the HSA for 2007 only extend to contributions up to, for 2007, \$2850 for individual coverage and \$5650 for family coverage.³² Under the MMA, tax-deductible contributions were also limited to the amount of the deductible, but this limit was removed by Congress in legislation late in 2006.³³

Money contributed to an HSA can be spent for “qualified medical expenses,” without being subject to income tax, but withdrawals are subject to both income tax and to a 10% excise tax if it is spent for other purposes.³⁴ “Qualified medical expenses” are broadly defined to include many things not covered by traditional health insurance, such as nonprescription drugs. HSA expenditures are controlled only by very

28. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 301, 110 Stat. 1936, 2037 (1996). Too few people signed up for the HIPAA demonstration project to allow program evaluation. General Accounting Office, *Medical Savings Accounts: Results from Surveys of Insurers*, 1 (1998).

29. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1201, and codified as amended at I.R.C. § 223. For a careful examination of these provisions, see Richard L. Kaplan, *Who's Afraid of Personal Responsibility? Health Savings Accounts and the Future of American Health Care*, 36 McGEORGE L. REV. 535, 548-56 (2005).

30. I.R.C. §§ 223(c)(2)(A)(i)(I) & (II) (2000). See also 2007 HSA Indexed Amounts, available at <http://www.ustreas.gov/offices/public-affairs/hsa/07IndexedAmounts.shtml>. The insurer may, however, cover preventive medical expenses, such as screenings or vaccinations, before the deductible is met. I.R.C. § 223(c)(2)(C), I.R.S. Notice 2004-23, 2004-15 I.R.B. 725.

31. I.R.C. §§ 223(c)(2)(A)(ii)(I) & (II) (2000). See also 2007 HSA Indexed Amounts, available at <http://www.ustreas.gov/offices/public-affairs/hsa/07IndexedAmounts.shtml>

32. I.R.C. § 223(b) (2000). See also 2007 HSA Indexed Amounts, available at <http://www.ustreas.gov/offices/public-affairs/hsa/07IndexedAmounts.shtml>.

33. H.R. 6408, § 303, 110th Cong. (2007).

34. I.R.C. § 223(f) (2000).

infrequent audits by IRS auditors who have no health care expertise³⁵. It is likely, therefore, that HSA expenditures will be limited only by the imagination, on the one hand, and good faith, on the other, of their owners.

If HSA funds are not spent for health care, they can be withdrawn for any purpose once the account holder dies, becomes disabled, or reaches the age of 65.³⁶ HSA funds may continue to be withdrawn after age 65 for qualified medical expenses, including Medicare premiums, free from taxation.³⁷ If they are used for other purposes after age 65, withdrawals are taxed as income, but no penalties attach.

The HSA has been joined by another new health savings device, the health reimbursement account or HRA. The HRA was created not by a statute but rather by the IRS. In 2002, the IRS determined that existing legislation authorized the offer of tax subsidies for employer contributions to health savings vehicles fully funded by employers.³⁸ The HRA is attractive to employers because the accounts can be held as notional accounts and need not be fully funded and because the funds in them also need not go with the employee if he or she leaves employment.

HSAs and HRAs have grown quite quickly over the past two years, although the number enrolled in these plans, like everything else about them, is contested. The Employee Benefits Research Institute estimates that about 1.3 million Americans are enrolled in a consumer-driven plan, though another 8.5 million Americans have a plan with a deductible high enough that they could set up an HSA.³⁹ The Center for Health Systems change estimates that about 1.43 million Americans have an employment-based HSA and 1.3 million have an HRA.⁴⁰ AHIP, the health insurance trade association, claims that 4.5 million Americans are in HSA-compatible

35. I.R.C. § 223(d)(2) (2000). Rev. Rul. 2003-102, 2003-38 I.R.B. 559; I.R.S. Notice 2004-2, 2004-2 I.R.B. 269.

36. I.R.C. § 223(f)(4) (2000).

37. I.R.C. §§ 223(d)(2)(C)(iv), (f)(1) (2000).

38. Rev. Rul. 2002-41.

39. Paul Fronstin & Sara R. Collins, *The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Care Survey*, Employee Benefit Research Center, Issue Brief No. 300, December, 2006.

40. Jon Gabel, Jeremy Pickreign, & Heidi Whitmore, *Behind the Slow Growth of Employer-Based Consumer-Directed Health Plans*, Center for Studying Health System Change, Issue Brief No. 107, December 2006, available at <http://www.hschange.org/CONTENT/900/900.pdf>.

plans.⁴¹ CDHC advocates claim that the number of Americans in consumer-driven plans will grow to 15-30 million over the next 5 to 10 years,⁴² but CDHC growth, rapid in the first two years, seems to have leveled off, at least in the employment-related market.⁴³

There has been a great deal of speculation as to how CDHC will affect health care in general and the health insurance market in particular.⁴⁴ Advocates believe, of course, that it will bring down costs while improving quality and access. Skeptics have worried that CDHC will lead to favorable selection, as healthy individuals and families choose consumer driven plans, leaving those with costly medical problems in comprehensive plans, which will become ever more costly as they cover a smaller and more

41. AHIP.org, *January 2007 Census Shows 4.5 Million People Covered by HSA/High-Deductible Health Plans*, Ctr. for Policy and Research, April 2, 2007, available at http://www.ahipresearch.org/PDFs/FINAL%20AHIP_HSAReport.pdf.

42. See U.S. Department of the Treasury, *Dramatic Growth of Health Savings Accounts*, <http://www.ustreas.gov/offices/public-affairs/hsa/pdf/fact-sheet-dramatic-growth.pdf> (14 million by 2010); *Health Savings Account Enrollees Predicted to Rise to 30 Million by 2009*, BUSINESS WIRE, May 10, 2007, available at <http://www.allbusiness.com/services/business-services/4342771-1.html>.

43. Fronstin & Collins, *supra* note 39, at 6.

44. Much of this speculation is found in the large and growing law review literature on consumer-driven health care and HSAs. For a sampling of the law review literature examining the policy implications of consumer-driven health care, see generally Marshall Kapp, *Patient Autonomy in the Age of Consumer-Driven Health Care: Informed Consent and Informed Choice*, 2 J. HEALTH & BIOMEDICAL L. 1 (2007); W. Eugene Basanta, *Consumer-Driven Health Care: Legal and Policy Implications*, 29 J. LEGAL MED. 1 (2007); Arnold J. Rosoff, *Consumer-Driven Health Care: Questions, Cautions, and an Inconvenient Truth*, 28 J. LEGAL MED. 11 (2007); Michele Melden, *Guarding Against the High Risk of High Deductible Health Plans: A Proposal for Regulatory Protections*, 18 LOY. CONSUMER L. REV. 403 (2006); David Pratt, *Healthy, Wealthy, and Dead: Health Savings Accounts*, 19 ST. THOMAS L. REV. 7 (2006); Amy Monahan, *The Promise and Peril of Ownership Society Health Policy*, 80 TUL. L. REV. 777 (2006); John V. Jacobi, *Consumer-Directed Health Care and the Chronically Ill*, 38 U. MICH. J. L. REF. 531 (2005); and Wendy K. Mariner, *Can Consumer-Choice Plans Satisfy Patients*, 69 BROOK. L. REV. 485 (2004). See also, exploring more closely the implications of consumer-driven health care for the legal relationships of patients and health care professionals and providers, Mark A. Hall and Carl E. Schneider, *Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643 (2008); Peter D. Jacobson and Michael R. Tunick, *Consumer-Directed Health Care and the Courts: Let The Buyer (And Seller) Beware*, 26(3) HEALTH AFF., May/June 2007 at 704; Mark A. Hall, *Paying for What You Get and Getting What You Pay For: Legal Responses to Consumer-Driven Health Care*, 69 LAW & CONTEMP. PROBS. 159 (2006); and E. Haavi Morreim, *High -Deductible Health Plans: New Twists on Old Challenges from Tort and Contract*, 59 VAND. L. REV. 1207 (2006).

expensive population, the familiar insurance death spiral.⁴⁵ Skeptics also wonder whether consumers have the information, or perhaps even the ability, to make wise consumer choices in health care.⁴⁶ The Rand HIE, for example, found that although insureds with higher deductibles did consume less health care, they cut back on high value health care to the same extent they cut back on low value health care.⁴⁷

Empirical evidence as to how CDHC is working out remains sketchy. It seems to be working out very well for banks. HSAs are the kind of low interest savings accounts that used to be the bread and butter of banks but that have been hard to market in recent years because they are bad financial investments. The HSA market is worth billions to banks, not just because banks pay low interest on these deposits, but also because they collect fees for establishing the accounts and for transactions.⁴⁸ HSAs also seem to be working out quite well for insurance companies that specialize in these accounts, several of which have bought or partnered with banks, and some of which are managing the accounts themselves.⁴⁹ Finally, HSAs are working out very well for wealthy individuals looking for a retirement tax shelter. Individuals in high tax brackets who have the choice of doing so are well advised to buy a eligible high deductible policy, cover any medical expenses from the deductible, and invest the legal maximum in the HSA, leaving it there for retirement to accumulate tax-free returns. This strategy could allow, by one scenario, a tax-free accumulation of \$1.5 million by retirement over a 40 year period.⁵⁰

It is less clear how CDHC is working out for employers, who purchase much of the private health insurance in the U.S., and for providers. High deductible policies are obviously somewhat less expensive than comprehensive policies, but if employers make a significant contribution to their employees' HSAs, they do not necessarily pay less overall.⁵¹ Some

45. JOST, *supra* note 1, at 133-134.

46. *Id.* at 137.

47. NEWHOUSE, *supra* note 15, at 162.

48. James G. Knight, *What HSAs Mean for Banks*, AMERICAN BANKER, April 29, 2005, available at <http://americanbanker.com/article.html?id=20050428X7JY10TC&queryid=630711033&hitnum=2>; Eric Dash, *Health Savings Promise a Windfall for U.S. Banks*, REDORBIT NEWS, Jan. 29, 2006, available at <http://www.redorbit.com/news/display/?id=373206>.

49. See JOST, HEALTH CARE AT RISK, *supra* note 1, at 23.

50. *Id.* at 22.

51. Kaiser Family Foundation & Health Research and Educational Trust, *Employer Health Benefits*, 2006 ANNUAL SURVEY, at 5 (2006), available at <http://www.kff.org/insurance/7527/>.

providers welcome the possibility of being able to bill consumers directly rather than to deal with insurers, but in fact most consumer-driven policies are structured so that the provider bills the insurer in any event, and the insurer then collects from the HSA.⁵² This assures consumers access to the insurer's bargaining power, but means that there is little savings in transaction costs. To the extent that providers bill consumers directly, they will experience savings in transactions costs and probably be able to charge higher prices, but they also have more risk exposure if consumers are unable to pay the bill.

The most important question, however, is how does consumer-driven health care affect consumers? First, there is some evidence of favorable selection toward consumer-driven plans, which seem to be chosen by those in better health, but the effect is not clear.⁵³ Because high deductible and high coinsurance plans have become quite common in recent years, even before the MMA, CDHC plans might be quite attractive to people with high medical costs because the law at least requires a cap on out-of-pocket limits. There is more evidence that CDHC plans are chosen by wealthier and better educated subscribers, which is not surprising.⁵⁴

There is also some evidence that CDHC reduces health care spending and use, and that participants in CDHC plans use more preventive care (which can under the law be excluded from deductibles) and comply better with prescribed treatment regimes.⁵⁵ Evidence on cost-savings, however, is still weak and confounded by the possibility of favorable selection, while evidence of quality improvement is far from conclusive. Some studies, for example, find that CDHC members are more likely to delay or forego needed medical care or the use of necessary medications.⁵⁶

The most troubling emerging evidence is that CDHC is further eroding the modest level of health care solidarity that private health insurance has brought about in this country. The public health insurance systems of all other developed countries are based, in the end, on the idea of solidarity—the belief that we are all at risk of disease and injury, that we all need to be

52. Timothy S. Jost & Mark A. Hall, *The Role of State Regulation in Consumer-Driven Health Care*, 31 AM. J.L. & MED. 395, 408 (2005).

53. Melinda Beeuwkes Buntin, et al., *Consumer-Directed Health Care: Early Evidence About Effects on Cost and Quality*, 25 HEALTH AFFAIRS 516, 519, available at http://content.healthaffairs.org/cgi/search?ck=nck&andorexactfulltext=and&resourcetype=1&disp_type=&author1=&fulltext=&pubdate_year=2006&volume=25&firstpage=516.

54. *Id.*; JOST, HEALTH CARE AT RISK, *supra* note 1, at 139.

55. JOST, HEALTH CARE AT RISK, *supra* note 1, at 145.

56. Fronstin & Collins, *supra* note 39, at 26, 29.

healthy to be productive members of society, and we ought all to contribute to the cost of health care to the extent of our ability to the cost of providing health care for all.⁵⁷ Employment-based health insurance has sustained a weak version of solidarity in the United States. Within employment settings, most employees have more or less equal access to health insurance, subsidized by the taxpayer, and with costs arguably borne somewhat disproportionately by higher income employees.⁵⁸

If employers move toward high deductible policies, however, an ever greater proportion of the cost of health care is going to be passed directly on to employees, particularly sick employees. Recent research shows that the majority of employees in high deductible plans are not offered a choice by their employer; they are simply given the high-deductible plan.⁵⁹ Thirty percent of employees with CDHC's moreover, receive no employer contribution to an HSA, and over half receive less than \$1000 per year.⁶⁰ Lower income employees, moreover, often contribute little or nothing themselves to an HSA. 27% of individuals in CDHC plans with incomes of less than \$50,000 a year contribute nothing to their HSA according to the EBRI survey.⁶¹ Of those who have had HSAs for a year or more, 23 percent rolled over nothing at the end of the year, 26%, \$500 or less.⁶² Overall 14% had nothing in their accounts at the time of the survey, 16% more \$200 or less.⁶³ 44% of those who did not open an account said that they did not do so because they did not have money to put into the account, 19% said that the tax benefits were not attractive enough to justify it.⁶⁴

Of course, high deductible accounts mean high exposure for those with high health care costs, and overwhelming evidence has emerged in recent years that consumers with high deductible accounts who lack health savings accounts forego necessary health care. Adults with health problems who have deductibles above \$500 (and particularly those with incomes below \$35,000 a year) are much more likely than those with lower deductibles to not fill a prescription, not get needed specialist care, to skip a

57. Jost, *Why Can't We Do What They Do*, *supra* note 2, at 433-34.

58. See Mark Pauly, *The Tax Subsidy To Employment-Based Health Insurance and the Distribution of Well-Being*, 69 LAW & CONTEMP. PROBS. 83, 89 (2006).

59. Fronstin & Collins, *supra* note 39, at 14. The same is true for about 2 in 5 employees in plans with HSAs/HRAs, Kaiser Family Foundation/Health Research and Educational Trust, *supra* note 50 at 103.

60. Kaiser Family Foundation, *supra* note 51, at 105.

61. Fronstin & Collins, *supra* note 39, at 18.

62. *Id.*

63. *Id.*

64. *Id.* at 14.

recommended test or follow-up visit, or report having a medical problem for which they have not sought medical care.⁶⁵ Patients with high deductibles are also much more likely to have medical bill or medical debt problems.⁶⁶ Nearly half of “underinsured” adults identified by a recent survey were contacted by a collection agency in the year prior to the survey regarding medical bills, while more than one-third said that they had to change their lives dramatically to pay for medical bills.⁶⁷

To put it bluntly, whatever else CDHC may accomplish, it seems to be bringing us tax subsidized retirement savings for the rich, high deductible health plans and financial misery for the poor. If one believes that health insurance is a bad idea, that health insurance must be seriously curtailed to bring about consumer choice and efficient markets, this cost in solidarity may be acceptable.

If one believes, however, that insurance is ultimately about solidarity, not efficiency, these issues are troubling. Health insurance obviously contributes to solidarity between the sick and the healthy, but can also build solidarity between the poor and the wealthy. Health insurance is also about security—knowing that when you need health care you will be able to get it, and to get it without missing a rent payment or a car payment. Efficiency is a good thing, of course, and the efficient distribution of health care should be encouraged. But the evidence that CDHC is bringing us efficiency is at best equivocal. The evidence that it is bringing about the breakdown of solidarity and threatening security is stronger. Health insurance is, in fact, a good idea, and we must look for ways to achieve efficiency while preserving what little risk sharing still exists in this country—perhaps even building on it. But how we can achieve this is beyond the scope of this essay.⁶⁸

65. See Karen Davis, Michelle M. Doty and Alice Ho, *How High Is Too High? Implications of High-Deductible Health Plans*, Commonwealth Fund Pub. No. 816, 2005, at 9, available at http://www.commonwealthfund.org/usr_doc/816_Davis_how_high_is_too_high_impl_HD_HPs.pdf?section=4039.

66. *Id.* at 11.

67. Cathy Schoen, et al., *Insured But Not Protected: How Many Adults are Underinsured?* HEALTH AFFAIRS, at w5-296, June 14, 2005, <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.289>.

68. See JOST, HEALTH CARE AT RISK, *supra* note 1, at 189-204 (exploring this topic further).

ASSIGNMENT OF LIABILITY INSURANCE RIGHTS FOR LATENT INJURY AND DAMAGE CLAIMS

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The efficiency of the American business community depends in part on the ability to transfer assets and stock with minimal limitations. Through mergers, asset sales, stock sales, corporate dissolutions, and other transactions, American businesses generally enjoy the freedom to change their structure to adapt to the constantly-evolving business environment.

In these transactions, there is often a link between the assets being transferred and the liabilities that are associated with those assets. For instance, under the state statutes governing corporate transactions, the surviving company in a merger typically is the successor to both the assets and liabilities of the merging companies. Similarly, corporate dissolutions often result in the transfer of the dissolving corporation's assets and liabilities to its shareholders. In other transactions, the link between assets and their related liabilities has been broken. For example, under many states' laws, assets generally may be sold free and clear of any liabilities associated with those assets, depending on the circumstances.

To ensure that transactions that could divorce assets from their related liabilities do not adversely affect third parties or the general public, legislatures and courts have developed a number of protections designed to allow society to obtain the economic benefits derived from such corporate transactions without incurring undesired consequences. For instance, through the laws governing fraudulent conveyances and successor liability, legislatures and courts have established safeguards that, when applicable and under certain circumstances, serve to prevent tort defendants from transferring their assets in a manner that would deprive tort claimants of a proper source for recovery.

This link between assets and liabilities is a two-way street. Just as courts have articulated rules to ensure that, in appropriate circumstances, the seller's liabilities follow the assets being transferred, courts also have devised principles for determining whether certain assets, such as insurance assets, follow the liabilities being transferred to a buyer.

For example, courts across the country have adjudicated a recurrent dispute between insurers and policyholders regarding the effect of "anti-

assignment” conditions¹ in insurance policies where the policyholder has attempted to transfer its insurance rights to a third party as part of a corporate or other transaction. This issue has been particularly difficult to resolve in the context of claims for insurance coverage for latent bodily injury and property damage, such as environmental, asbestos and other delayed-manifestation claims where the bodily injury or property damage already took place (or began to take place) prior to the transfer of insurance rights at issue but was not discovered until years after the transfer.

In such disputes, insurers often contend that anti-assignment conditions preclude the policyholder from transferring its insurance rights to a third party without the insurers’ consent, even where the transaction provides that the third party will assume the liabilities to which the insurance assets related (hereinafter, the “Insurer Position”). In response, the entity to which the insurance rights have been assigned (the “Successor Insured”) typically asserts that anti-assignment conditions cannot be used by insurers to avoid providing coverage for occurrences that already took place prior to the transfer, because the occurrences gave the assigning policyholder “chose in action” under the policies that were freely transferable, with or without the insurers’ consent (hereinafter, the “Successor Insured Position”).²

Courts have resolved this dispute in different ways. A number of courts have adopted the Successor Insured Position that, while an insurer cannot be required to insure a third party for new occurrences that relate solely to the third party’s conduct after the transfer in question, a policyholder is free to assign or otherwise transfer its insurance rights

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1. These anti-assignment conditions often purport to provide that the insurance policy, or interests thereunder, may not be assigned without the insurer’s consent. *See, e.g.*, I MILLER’S STANDARD INSURANCE POLICIES ANNOTATED, at 421.4 (2006) (“Assignment of interest under this policy shall not bind the [insurer] until its consent is endorsed hereon.”).

2. The use of the terms “Successor Insured” and “Successor Insured Position” is a simplification and is not intended to suggest that all insureds will or should have the same position in a dispute over the transfer of insurance rights in a corporate transaction. Ultimately, resolution of such issues will turn on the unique circumstances and facts of each case and hence the discussion in this Article is necessarily general. The specific language of the transactional documents and the insurance policies should be consulted as such language may affect the transfer of insurance rights.

relating to occurrences that began prior to the transfer without having to obtain the insurer's consent. On the other hand, other courts, including most notably the California Supreme Court in *Henkel Corp. v. Hartford Accident & Indem. Co.*,³ have adopted the Insurer Position and held that an anti-assignment condition precluded the policyholder from transferring its insurance rights without the insurer's consent, including its liability insurance rights for bodily injury that had already happened prior to, but was not discovered until after, the transfer in question. As a result, the insurers in *Henkel* and these other cases were able to avoid paying substantial amounts in coverage to the Successor Insured to which the policyholder had attempted to assign coverage. Based on *Henkel* and similar decisions, insurers are now more aggressively relying on anti-assignment conditions in their policies as a basis for denying coverage where the entity seeking coverage is a successor to the policyholder, whether by way of merger, stock sale, dissolution, or asset sale.⁴

From the Successor Insured's perspective, this insurer effort arguably threatens to undermine the efficiency of corporate transactions while benefiting the insurers alone. On this view, insurers are seeking enormous windfalls through the virtual elimination of their coverage obligations pursuant to historical policies, for which they collected substantial premiums, by way of a corporate transaction or other subsequent circumstances having nothing to do with the scope of the risk insured under the policies. According to these Successor Insureds, courts should reject the *Henkel* decision and remain committed to the position that anti-assignment conditions do not preclude the transfer of liability insurance rights for losses that took place prior to the transfer in question. As discussed in more detail below, this position provides that, whether the corporate transaction resulting in the transfer of rights to coverage was a merger, stock sale, dissolution, or asset sale, the insurer's consent is not required to transfer such insurance rights even where the injury or damage

3. 62 P.3d 69 (Cal. 2003).

4. The emergence of these issues, especially in light of the *Henkel* decision, has been the subject of significant analysis by commentators. See, e.g., Seth A. Tucker and Ann-Kelley Kemper, *You Have the Liabilities, But Do You Have The Coverage? Coverage Rights for IBNR Liabilities Under Occurrence-Based Liability Policies Issued to a Corporate Predecessor*, 16 Coverage 3 (May/June 2006); Gregory J. May, *Successors' Rights to Insurance Coverage for Predecessors' Preacquisition Activities: Recent Developments*, 40 Tort & Ins. L.J. 911 (2004-2005); Tom Baker, John Buchanan, and Marianna Horton, *Meet Your New Insured: Successors' Rights to Insurance Assets in Corporate Transactions*, 4 Coverage 1 (2004).

at issue did not manifest until years after the transaction.⁵ In recent months, there have been a number of developments in the decisional law addressing this tension between the Successor Insured Position and Insurer Position on the transferability of rights to insurance coverage.⁶

I. AN INSURER'S CONSENT IS GENERALLY NOT NEEDED FOR A POLICYHOLDER'S INSURANCE RIGHTS TO TRANSFER BY MERGER

A policyholder's insurance assets (along with its liabilities) generally transfer to the surviving corporation in a merger, even where the insurer has not consented to the transfer, notwithstanding any anti-assignment conditions in the insurer's policy.

All fifty states have adopted some form of merger statute.⁷ Merger statutes generally provide that the surviving corporation, upon the effective date of the merger: (i) assumes all of the rights, privileges, powers, and immunities of the non-surviving corporation (provided they are not inconsistent with the articles of incorporation of the surviving corporation and that if the merger is with a foreign corporation they are not inconsistent with any limitation in the domestic jurisdiction), and (ii) is subject to and assumes the prior duties and liabilities of the non-surviving corporation.⁸

For instance, Section 259(a) of the General Corporation Law of the State of Delaware ("DGCL") provides that when a merger becomes effective, the separate existence of the non-surviving corporation ceases and the surviving corporation possesses "all the rights, privileges, powers and franchises as well of a public as of a private nature" and is "subject to all the restrictions, disabilities and duties" of each of the merged corporations. As Section 259(a) further states:

5. This article focuses on the question of an insured's continuing right to its historical insurance coverage, notwithstanding changes in corporate structures and other transactions; it does not address the competing interests of multiple potential insureds with respect to the same policies, which can present different considerations (such as, for example, policyholders that intended to retain their insurance rights and not transfer them in the corporate transaction at issue). This article also does not focus in detail on the related issue of whether and under what circumstances historical liabilities and related rights to insurance coverage may be transferred to a Successor Insured by "operation of law."

6. See *infra* section (IV)(C)(5) for a discussion of some of these recent developments.

7. See Jonathan R. Macey, Macey on Corporation Law § 9.01[B] (2003).

8. *Id.*

*The rights, privileges, powers and franchises of each of said [merging] corporations, and all property, real, personal and mixed, and all debts due to any of said constituent corporations on whatever account, as well for stock subscriptions as all other things in action or belonging to each of such corporations shall be vested in the corporation surviving or resulting from such merger or consolidation; and all property, rights, privileges, powers and franchises, and all and every other interest shall be thereafter as effectually the property of the surviving or resulting corporation as they were of the several and respective constituent corporations*⁹

Consistent with Section 259(a), courts have held that a merger results in the transfer of the non-surviving corporation's rights and obligations under its insurance policies to the surviving corporation by operation of law.¹⁰ Further, such a transfer does not violate any non-assignment provision in such policies.¹¹

9. DEL. CODE ANN., tit. 8 § 259 (a)(2002) (emphasis added); *Heit v. Tenneco, Inc.*, 319 F. Supp. 884, 887 (D. Del. 1970) (“[Section] 259 provides that when a merger becomes effective all assets of the merged corporation, including causes of action which might exist on its behalf, pass by operation of law to the surviving company.”); *cf. Texaco Refining & Mktg., Inc. v. Delaware River Basin Comm’n*, 824 F. Supp. 500, 507 (D. Del. 1993) (“A statutory merger . . . results in a combination of the two corporations with the surviving corporation attaining the property, rights, and privileges of the absorbed corporation, as well as retaining its own property, rights, and privileges.”).

10. *Brunswick Corp. v. St. Paul Fire & Marine Ins. Co.*, 509 F. Supp. 750, 752-753 (E.D. Pa. 1981) (“under [Delaware, Maryland and Pennsylvania] corporation law, the surviving corporation in a merger is vested with all rights and benefits under a liability insurance policy formerly due the merged corporation.”); *see also Knoll Pharm. Co. v. Auto. Ins. Co.*, 167 F. Supp. 2d 1004, 1010 (N.D. Ill. 2001) (applying Illinois law, “once a merger is established, the successor corporation takes on the obligations and liabilities under the insurance policies”); *Texaco A/S, v. Commercial Ins. Co.*, No. 90 Civ. 2722, 1995 WL 628997, at *6 (S.D.N.Y. Oct. 26, 1995) (holding under New York law that surviving corporations of mergers were named insureds under liability policies issued to merged entities since “the risk contemplated by the insurers is not substantially altered by requiring them to provide coverage for the pre-acquisition activities of the merged corporation”), *vacated on other grounds*, 160 F.3d 124 (2d Cir. 1998); *Aetna Life & Cas. v. United Pac. Reliance Ins. Co.*, 580 P.2d 230 (Utah 1978) (“logical conclusion is that the surviving corporation . . . simply stands in the same position as that occupied by the merged corporation . . . prior to the merger”); *Paxton & Vierling Steel Co. v. Great Am. Ins. Co.*, 497 F. Supp. 573, 578 (D. Neb. 1980) (holding that it is “logical, reasonable and, most importantly, fair” that insurance rights transfer from merging corporation to surviving corporation by operation of law); *Chatham Corp. v. Argonaut Ins. Co.*, 334 N.Y.S.2d 959 (Sup. Ct. 1972) (observing that the non-surviving corporation's insurance policy

II. AN INSURER'S CONSENT TYPICALLY WOULD NOT BE NEEDED FOR A POLICYHOLDER'S INSURANCE RIGHTS TO TRANSFER IN A STOCK SALE

The conveyance of all of a corporation's stock generally transfers ownership of the corporate entity as a whole, with the corporation generally retaining all of its assets unless certain assets are expressly excluded from the transaction.¹² Hence, because the sale of a policyholder's stock alone ordinarily does not involve an "assignment" of insurance policies, an insurer's consent typically would not be required.

When a policyholder's stock is sold, insurers sometimes contend that their consent is required for that policyholder to be able to keep its own insurance rights. In response, Successor Insureds may challenge this assertion on public policy grounds, contending that, if the insurers' position were taken seriously, public companies, whose stock is bought and sold every day, would unwittingly forfeit their insurance rights each time a share of stock were sold. Indeed, the insurers' position has been rejected by several courts for that reason.

For example, the court in *Knoll Pharm. Co. v. Automobile Ins. Co.* held that a company whose stock is being sold need not obtain the consent of its insurers to retain its insurance rights.¹³ In *Knoll*, all of the stock of the named insured was sold to a third party.¹⁴ The named insured later was

"automatically vested in plaintiff as the surviving corporation by virtue of the provisions of . . . the Business Corporation Law").

11. See, e.g., *Imperial Enterprises, Inc. v. Fireman's Fund Ins. Co.*, 535 F.2d 287, 292-93 (5th Cir. 1976) ("Thus, it is our conclusion that the no-assignment clause should not be applied ritualistically and mechanically to forfeit coverage in these circumstances"); *Knoll Pharm.*, 167 F. Supp.2d at 1011 n.7 (finding no increased risk associated with the statutory merger since the insurers were only liable on those claims against the surviving corporation that arose out of the covered acts of the insured corporation and refusing to enforce no-assignment clause); *Texaco*, 1995 WL 628997, at *6 (successors by merger entitled to access coverage issued to merged entities "notwithstanding the no-assignment clause, because the transfer of substantially all the assets of the corporation results in the transfer of liability as well, irrespective of any agreement otherwise"); *Paxton*, 497 F. Supp. at 581 ("It seems well recognized that a provision limiting assignment in an insurance policy simply does not apply to a transfer occurring by operation of law.").

12. See, e.g., *Terrific Promotions, Inc. v. Dollar Tree Stores, Inc.*, 947 F. Supp. 1243, 1248 (N.D. Ill. 1996); *SCA Disposal Servs. of New England, Inc. v. Central Nat'l Ins. Co.*, No. 900393C, 1994 WL 879687, at *4 (Mass. Super. Apr. 12, 1994) (holding that the company whose stock was purchased retained its insurance rights).

13. *Knoll Pharm.*, 167 F. Supp. 2d 1004, 1008 (N.D. Ill. 2001).

14. *Id.* at 1006.

merged with the plaintiff,¹⁵ and the plaintiff asserted that it was therefore the successor to the named insured's insurance rights.¹⁶ While the insurers did not dispute that the plaintiff succeeded to whatever insurance rights the named insured had at the time of the merger, the insurers claimed that the named insured had no insurance rights after the earlier sale of its stock.¹⁷ In this regard, the insurers argued that the named insured's insurance rights did not transfer with the insured in the stock sale because the insurers' consent was not obtained.¹⁸ Rejecting the insurers' arguments, the court held that the stock sale did not involve any change in the insured's rights or obligations under the insurance policies.¹⁹

In an effort to distinguish *Knoll* and similar decisions, insurers frequently cite to other cases that they assert stand for the proposition that their consent is needed for a policyholder to retain its insurance rights when its stock is being sold. However, Successor Insureds may dispute whether such cases support the insurers' position. For instance, in *SCA Disposal Services of New England, Inc. v. Central National Insurance Company of Omaha*,²⁰ the purchaser of an insured's stock argued that it could access the insured's insurance, notwithstanding anti-assignment conditions, because the purchase of the insured's stock was akin to a merger. The court rejected the purchaser's right to access the insured's insurance because, in a stock sale, the company whose stock is being sold retains all of its assets and liabilities:

[T]he transfer of [the insured] to [the purchaser's predecessor] was accomplished through stock purchase, not by statutory merger. . . . [The insured] retained its separate corporate identity after the purchase. *When acquisition is accomplished by stock purchase, all legal attributes of the acquired entity continue.*²¹

15. *Id.*

16. *Id.* at 1007.

17. *Id.* at 1010.

18. *Id.* The insurers also argued that the insurance rights did not transfer with the insured because the language of the purchase agreement expressly excluded insurance rights from the transfer. However, the court held that the exclusion was referring to the parent's insurance contracts, not the insured's. *Id.* at 1009.

19. *Id.* at 1007-08.

20. *SCA Disposal Servs. of New England*, No. 900393C, 1994 WL 879687, at *4 (Mass. Super. Apr. 12, 1994).

21. *Id.* at *4 (emphasis added).

The *SCA* court did not indicate that the insurers' consent was needed for the insured to retain its insurance rights through the stock sale (and indeed the court went on to find coverage for the insured for its environmental liabilities under a policy not containing a pollution exclusion).²²

Similarly, in *Independent Petrochemical Corp. v. Aetna Casualty & Surety Co.*,²³ the court held that a subsidiary whose stock was sold lost coverage because it had been covered under its parent's policy as a "subsidiary." After the parent sold the stock of the subsidiary, the latter ceased to be a subsidiary and, therefore, was no longer covered under the parent's policy for *post-sale* losses. Critically, the court did not hold that the subsidiary lost coverage because it failed to obtain the insurer's consent. As the Court of Appeal clarified on appeal: "At the time of the stock transfer from [the parent] to [the third party], [the former subsidiary] lost its status as a subsidiary and therefore no longer fell within the ambit of the [defendant's] policy."²⁴

In addition, other cases often cited by insurers do not hold that an anti-assignment condition in an insurance policy requires that the insurer's consent be obtained for the insured to retain its insurance rights when its stock is sold:

*Bunzl Pulp & Paper Sale, Inc. v. Golder*²⁵ – No party in the case asserted that the sale of the stock of the insured in any way affected the insured's own insurance rights. The company that bought the insured's stock did assert that it could access its new subsidiary's insurance policies, but the court rejected

22. *Id.* at *10-11.

23. *Indep. Petrochemical Corp. v. Aetna Cas. & Sur. Co.*, 654 F. Supp. 1334 (D.D.C. 1986), *aff'd in part, rev'd in part*, 944 F.2d 940 (D.C. Cir. 1991).

24. *Indep. Petrochemical Corp.*, 944 F.2d at 948. The decision in *Home Ins. Co. v. Service Am. Corp.*, 662 F. Supp. 964 (N.D. Ill. 1987), similarly does not support the contention that an insurer's consent is needed for a policyholder to retain its insurance rights when its stock is being sold. Like *Independent Petrochemical*, the *Home* case involved a company that was insured as a "subsidiary" under its parent's policy, but then the company was sold to a third party, thus causing the company to lose its status as a covered "subsidiary." *Id.* at 967.

25. *Bunzl Pulp & Paper Sale, Inc. v. Golder*, No. Civ. A., No. Civ. A. 90-4303, 1995 WL 89026 (E.D. Pa. Mar. 2, 1995).

this claim because the policy “did not insure the shareholders of [the insured].”²⁶

*Lawyers Title Ins. Corp. v. CAE-Link Corp.*²⁷ – This decision did not hold that an insurer’s consent is required for an insured to retain its insurance rights when its stock is sold.²⁸ Nor did this decision involve a sale or assignment of insurance rights or policies, or even anti-assignment conditions.²⁹ Rather, the *Lawyers Title* decision involved a form of insurance entirely different from general liability insurance – title insurance – with unique policy language not found in standard-form liability policies.³⁰ Specifically, the title insurance in *Lawyers Title* provided coverage for the “insured,” which was defined to mean the named insured and “those who succeed to the interest [in the real estate at issue] of [the named insured] by operation of law as distinguished from purchase including, but not limited to, heirs, distributees, devisees, survivors, personal representatives, next of kin, or corporate or fiduciary successors.”³¹ Because the defendant acquired the real estate at issue through a “purchase,” the court held that it did not qualify as an insured under this definition.³²

*In re Asian Yard Partners*³³ – This decision did not involve insurance policies or language similar to the typical standard-form “Assignment” conditions.³⁴ The partnership agreement at issue included a “No Transfer” provision that stated: “No Partner may sell, assign, transfer, give,

26. *Id.* at *3.

27. *Lawyers Title Ins. v. CAE-Link Corp.*, 878 F. Supp. 767 (D. Md. 1994).

28. *Id.*

29. *Id.*

30. *Id.* at 768.

31. *Id.*

32. *Id.* at 771.

33. *In re Asian Yard Partners*, Nos. 95-333-PJW, 95-334-PJW, 1995 WL 1781675 (Bankr. D. Del. Sept. 18, 1995).

34. *Id.*

hypothecate or otherwise encumber . . . directly or indirectly, or by operation of law or otherwise, any interest in the Partnership”³⁵ The sole asset of one of the partners, AOC, was its 1% general partnership interest. One of the limited partners, AYP, owned 100% of the stock of AOC.³⁶ When AYP sought bankruptcy court approval of the sale of all of AOC’s stock, the court concluded that this sale would constitute an indirect sale of AOC’s 1% general partnership interest in the partnership, and thus that the sale violated the “No Transfer” provision.³⁷

Accordingly, Successor Insureds may argue that, because the sale of a policyholder’s stock does not involve the assignment of any insurance rights (let alone insurance policies), an insurer’s consent is typically not required under normal circumstances for the policyholder to retain its insurance rights through the sale.

III. AN INSURER’S CONSENT GENERALLY WOULD NOT BE NEEDED TO TRANSFER INSURANCE ASSETS AS PART OF A POLICYHOLDER’S DISSOLUTION

When a corporate policyholder is dissolved and its assets transferred to a third party (typically its shareholder(s)), insurers frequently contend that this transfer of insurance assets requires their consent under the “Assignment” conditions in their policies.³⁸ Successor Insureds will ordinarily be able to refute the insurers’ position, relying on two principal grounds.³⁹

First, in cases involving the transfer of insurance rights in the context of a corporate dissolution, courts have held that an anti-assignment condition does not apply to the transfer of insurance assets relating to pre-transfer losses, even where those losses are ongoing, but not discovered until after the transfer.⁴⁰ For instance, in *Sharon Steel Corp. v. Aetna*

35. *Id.* at *5.

36. *Id.* at *1.

37. *Id.* at *6-7.

38. *See*, Nat’l Am. Ins. Co. v. Jamison Agency, Inc., 501 F.2d 1125, 1128 (8th Cir. 1974).

39. *Id.*

40. *Sharon Steel Corp. v. Aetna Cas. & Sur. Co.*, 931 P.2d 127 (Utah 1997).

Casualty & Surety Co., the policyholder had engaged in operations that were causing undiscovered environmental property damage.⁴¹ In 1979, the policyholder was dissolved, and its remaining assets were transferred to a liquidating trust.⁴² In the mid-1980's, the environmental property damage was discovered, and the Environmental Protection Agency (EPA) demanded that the liquidating trust clean up the site of the operations.⁴³ When the trust sought coverage under the policyholder's policies, one of the insurers contended that an anti-assignment condition had precluded the transfer of the policyholder's insurance assets to the trust.⁴⁴ Rejecting the insurer's position, the Utah Supreme Court held that all of the policyholder's insurance assets had transferred to the liquidating trust, despite the anti-assignment condition.⁴⁵

One of the cases relied on by the *Sharon* court -- *National American Insurance Co. v. Jamison Agency, Inc.* -- held that assignment of an insurance policy and coverage for *post*-assignment losses of the assignee are not precluded by an anti-assignment condition in the policy, where the assignment of the insurance policy did not increase the risk of the insurer.⁴⁶ In *Jamison*, the policyholder purchased a fire insurance policy from the insurer.⁴⁷ Soon after the issuance of the policy, one of the defendants purchased all of the stock of the policyholder.⁴⁸ Several months after this stock purchase, the policyholder was dissolved, and all of its assets were distributed to its sole shareholder, including the fire policy.⁴⁹ After the dissolution and assignment, a fire caused damage to the insured premises, and the shareholder sought coverage under the policy. Rejecting the anti-assignment condition as a basis for denying coverage, the court held that such conditions do not apply to the assignment of policies providing coverage for *post*-assignment losses if "the assignment involves no increase in risk to the insurer."⁵⁰ Finding that the dissolution of the policyholder and assignment of the insurance policy resulted in no such increase in the risk to the insurer, the court concluded that the anti-assignment condition

41. *Id.* at 130.

42. *Id.*

43. *Id.*

44. *Id.* at 139 n.15.

45. *Id.* (citing cases finding anti-assignment conditions inapplicable).

46. *Nat'l Am. Ins. Co. v. Jamison Agency, Inc.*, 501 F.2d 1125, 1129 (8th Cir. 1974).

47. *Id.*

48. *Id.*

49. *Id.*

50. *Id.* at 1128.

did not apply.⁵¹ To hold otherwise, according to the court, would “place form over substance and would conflict with the oft-expressed doctrine that forfeitures of insurance policies are not favored in the law and are to be avoided whenever possible.”⁵²

Second, certain dissolutions arguably constitute de facto mergers for which an insurer’s consent is not required in order to transfer insurance assets. Courts addressing dissolutions have concluded that, where a company purchases all of the stock of another company and then subsequently dissolves its new subsidiary, transferring all of the subsidiary’s assets and liabilities to it, a de facto merger may have occurred.⁵³ For example, in *Arnold Graphics Industries, Inc. v. Independent Agent Center, Inc.*, the court held that there had been a de facto merger between a parent and its subsidiary where, some time after purchasing all of the subsidiary’s stock, the assets and liabilities of the subsidiary were transferred to the parent and the subsidiary dissolved.⁵⁴ The court came to this conclusion even though the subsidiary had conducted business as a distinct legal entity for about a year between the parent’s purchase of its stock and the transfer of the subsidiary’s assets to the parent, stating that “there is no requirement that all of the events that are necessary to a finding of de facto merger occur at the same time.”⁵⁵ As discussed above in Section I, Successor Insureds may assert that the transfer of insurance rights through a merger (“de facto” or otherwise) does not require the consent of insurers.

Notwithstanding these two arguments advanced by Successor Insureds, in an effort to avoid providing coverage to the sole shareholder parent of a policyholder that has been dissolved, insurers may repeat their contention that insurance must pass “by operation of law” for the anti-assignment condition of their policies to not apply and that a transfer of assets through

51. Jamison, 501 F.2d at 1128.

52. *Id.*; see also *Paxton & Vierling Steel Co. v. Great Am. Ins. Co.*, 497 F. Supp. 573, 580 (D. Neb. 1980) (noting that, with respect to whether an anti-assignment condition applies, the difference between a transfer of assets upon corporate dissolution and a transfer based on a merger is not material, as the inquiry in both cases is focused on whether the insurer’s risk has been materially increased).

53. *Arnold Graphics Indus., Inc. v. Indep. Agent Ctr., Inc.*, 775 F.2d 38, 42 (2d Cir. 1985).

54. *Id.*

55. *Id.*; see also *Hoche Prods. v. Jayark Films Corp.*, 256 F. Supp. 291, 295-96 (S.D.N.Y. 1966) (finding de facto merger where (1) company purchased all of the stock of third party, (2) third party then assigned all of its assets to the company, and (3) third party later dissolved).

a dissolution is not a transfer “by operation of law.” However, Successor Insureds may attempt to refute this insurer position on two grounds. First, as discussed below, insurance rights for pre-transfer liabilities arguably do not have to transfer by operation of law to survive an anti-assignment condition.⁵⁶ Second, assuming *arguendo* that this standard were controlling, the cases regularly cited by insurers arguably do not support their contention that such a transfer in connection with a corporate dissolution is not “by operation of law.”

To support their position that their consent is needed for the transfer of insurance rights in the context of a corporate dissolution, insurers have cited to the decision in *Snellman v. A.B. Dick Co.*⁵⁷ However, Successor Insureds may contend that the *Snellman* decision supports their position that a successor may recover under a contract, such as an insurance policy, for the damages suffered, but not discovered, by its predecessor prior to the transfer of the predecessor’s rights. In *Snellman*, the plaintiff’s subsidiary entered into an agency agreement with the defendant.⁵⁸ Unbeknownst to the plaintiff or his subsidiary, the defendant began to engage in activities that allegedly constituted breaches of the agreement.⁵⁹ The subsidiary was later dissolved.⁶⁰ Subsequently, the plaintiff discovered the defendant’s activities and sued for breach of the agency agreement between the dissolved subsidiary and the defendant.⁶¹ The defendant asserted that the agency agreement had terminated at the time of the subsidiary’s dissolution in light of a broadly-drafted anti-assignment condition in the agreement.⁶² Because the agreement was an executory contract and the court believed that the plaintiff’s subsidiary should not be permitted to assign its ongoing duties under the agency agreement to a third party with whom the defendant had not agreed to contract, the court held that the anti-assignment condition precluded the contract from continuing to be in effect after the dissolution.⁶³ However, to the extent that the plaintiff’s breach-of-contract claim was based on the defendant’s conduct before the subsidiary was dissolved, the court, relying on Illinois’ statute regarding corporate

56. See *infra* Section IV.A.

57. No. 81C3048, 1987 WL 8619, at *10 (N.D. Ill. Mar. 24, 1987).

58. *Id.* at *2.

59. *Id.* at *10 (citing plaintiff’s allegations of breaches of agency agreement that may have occurred prior to dissolution of plaintiff’s subsidiary).

60. *Id.* at *1.

61. *Id.* at *2.

62. *Id.* at *3.

63. *Snellman*, 1987 WL 8619 at *9.

dissolution, held that the plaintiff retained the subsidiary's cause of action despite the dissolution.⁶⁴ Thus, even though the subsidiary was not aware at the time of its dissolution that the defendant had already breached their agreement, the subsidiary's causes in action for this undiscovered breach were transferred to the plaintiff at the time of its dissolution under Illinois law, and this transfer was unaffected by the anti-assignment condition included in the agreement.

In addition to *Snellman*, insurers frequently rely on *Butera v. Attorneys' Title Guar. Fund, Inc.*, for the proposition that the transfer of insurance rights to the sole shareholder of a policyholder upon the policyholder's dissolution is not a transfer by "operation of law."⁶⁵ However, Successor Insureds may argue that *Butera* is inapposite for four principal reasons. First, the *Butera* case did not involve an anti-assignment condition, but rather the interpretation of a definition of "insured" that is unique to title insurance policies.⁶⁶ Second, the definition of "insured" at issue in *Butera* specifically provided that transfers "by operation of law" did not include transfers by "purchase."⁶⁷ Therefore, even if it were relevant whether a transfer was "by operation of law" as that phrase is used in its ordinary legal meaning, the *Butera* case involved a definition of "by operation of law" that was unique to the particular policy language at issue and thus arguably provides no guidance regarding the ordinary legal meaning of that phrase. Third, *Butera* did not involve transfers of assets upon dissolution. Fourth, the court indicated that a transfer of property to an insured's sole shareholders as a result of the insured's dissolution would constitute a transfer "by operation of law."⁶⁸ Instead, the court held that a separate purchase of the property by a third party from the insured was a "purchase" and therefore not a transfer "by operation of law" under the policy.⁶⁹

64. *Id.* at *10.

65. *Butera v. Attorneys' Title Guar. Fund, Inc.*, 747 N.E.2d, 949, 954 (Ill. App. Ct. 2001).

66. *Id.* at 951, 952.

67. *Id.* at 951.

68. *Id.* at 952-53 (discussing favorably the decision in *Historic Smithville Development Co. v. Chelsea Title & Guar. Co.*, 445 A.2d 1174 (N.J. Super. Ch. Div. 1981), *aff'd in part, rev'd in part on other grounds* 464 A.2d 1177 (N.J. Super. App. Div. 1983), in which the court held that "if a corporation, in dissolution or otherwise, transfers all of its assets to some other entity or to an individual, the transferee is a 'successor' in every sense of the word").

69. *Id.* at 954.

Finally, insurers often cite to the decision in *Bunzl Pulp & Paper Sale, Inc. v. Golder*, for the proposition that dissolutions do not transfer insurance policies containing anti-assignment clauses because dissolutions are not transfers by “operation of law.”⁷⁰ In *Bunzl*, the insured transferred title to real estate to its parent and then was dissolved.⁷¹ The decision does not explain what happened to the insured’s other assets, including its insurance rights, at dissolution. The parent asserted that it could access the insured’s liability policy either (i) because it owned all of the stock of the insured when the insured dissolved, or (ii) because the insured had transferred real estate to the parent.⁷² The court rejected both of these arguments. First, the insurance policy did not insure the shareholders of the insured and therefore the parent was not insured under the policy by virtue of its ownership of the insured’s stock.⁷³ Second, the mere acquisition by deed from the insured of title to real estate did not also give the parent the insured’s insurance rights relating to that property.⁷⁴ These holdings typically are irrelevant to cases involving the question of whether the sole shareholder parent of a policyholder succeeds to that policyholder’s insurance rights upon the policyholder’s dissolution, because, unlike the transfer of real estate by deed in *Bunzl* which was limited to real estate and did not seek to transfer insurance assets, the dissolutions of corporate policyholders typically include the transfer of all assets, including insurance assets and liabilities to the sole shareholder parent.

In sum, Successor Insureds have a number of arguments to distinguish the Insurers’ cases and to support the Successor Insureds’ Position that insurance assets may be transferred to them in the context of the policyholder’s dissolution, notwithstanding anti-assignment conditions contained in the policies at issue.

IV. TRANSFERRING INSURANCE ASSETS AS PART OF AN ASSET PURCHASE AGREEMENT

Bolstered by the *Henkel* decision, insurers are now asserting more aggressively that the anti-assignment conditions in their policies preclude the transfer of historical insurance rights without their consent.

70. No. Civ. A. 90-4303, 1995 WL 89026, at *2, 3 (E.D. Pa. Mar. 2, 1995).

71. *Id.* at *2.

72. *Id.* at *2,3.

73. *Id.*

74. *Id.* at *3.

Specifically, even though a purchaser may have intended to obtain all of the assets, including insurance rights, of a seller, insurers contend that their anti-assignment conditions operate to block the transfer of insurance rights and to defeat the purchaser's and seller's intent. This conclusion, and the *Henkel* decision upon which it rests, is currently the subject of substantial coverage litigation.

a. CASES ADDRESSING WHETHER THE TRANSFER OF INSURANCE RIGHTS FOR COVERAGE FOR PRE-TRANSFER EVENTS REQUIRES AN INSURER'S CONSENT

A number of courts addressing the issue have held that anti-assignment conditions do not preclude a transferee from obtaining coverage under the transferor's policies for the liabilities arising out of pre-transfer events. These courts have reasoned that, because the event causing the liability already took place prior to the transfer, the transfer of the insurance rights relating to this liability does not materially increase the risk to the insurer.⁷⁵

For instance, the Supreme Court of Illinois has held that rights to insurance may be assigned without the insurers' consent where the loss has taken place prior to the assignment.⁷⁶ In *Lain*, the beneficiary of a life insurance policy assigned the policy benefits after the death of the insured to a funeral home to cover the insured's funeral expenses.⁷⁷ The insurer denied coverage, arguing that it had not given consent to the assignment. Rejecting the insurer's reliance on the anti-assignment condition, the court held that such conditions do not preclude an assignment of insurance benefits where the assignment takes place after the loss has occurred:

The general rule, supported by a great wealth of authority, is that general stipulations in policies, prohibiting assignment thereof except with the insurer's

75. See, e.g., *Elat, Inc. v. Aetna Cas. & Sur. Co.*, 654 A.2d 503, 505-06 (N.J. Super. Ct. App. Div. 1995) (rejecting the insurer's reliance on an anti-assignment condition where the assignment took place after the property damage at issue had occurred, stating: "[T]he purpose behind a no-assignment clause in a casualty or liability policy . . . is to protect the insurer from insuring a different risk than intended. Assignment of the right to collect or to enforce the right to proceed under a casualty or liability policy does not alter, in any meaningful way, the obligations the insurer accepted under the policy. The assignment only changes the identity of the entity enforcing the insurer's obligation to insure the same risk.").

76. *Lain v. Metro.Life Ins. Co.*, 58 N.E.2d 587, 588 (Ill. 1945).

77. *Id.* at 588.

consent, or upon giving some notice, or like conditions, have universally been held to *apply only to assignments before loss*, and, accordingly, not to prevent an assignment after loss, of the claim or interest of the insured in the insurance money then due in respect to the loss.⁷⁸

Similarly, courts applying New York law have found that rights to insurance may be assigned without the insurer's consent where the event from which the liability arose took place prior to the assignment.⁷⁹

In addition, courts in other jurisdictions that have considered the issue agree that insurance benefits may be transferred without the insurer's consent despite the presence of an anti-assignment condition, where the injury or damage in question took place prior to the transfer.⁸⁰

78. *Id.* (emphasis added).

79. *Bronx Entm't v. St. Paul's Mercury Ins. Co.*, 265 F. Supp. 2d 359, 363 (S.D.N.Y. 2003) (following *Holt*, and stating that, even though the policy at issue contained an anti-assignment condition, the assignee of insurance rights could maintain an action against the insurer for the named insured's pre-assignment business interruption damages); *Employers Ins. of Wausau v. Duplan Corp.*, No. 94 Civ. 3143(CSH), 1999 WL 777976, at *32 (S.D.N.Y. Oct. 20, 1999) (confirming that an entity that is not a named insured may invoke rights under an insurance policy "when the party seeking coverage (1) is the surviving corporation in a merger with the insured; (2) is legally regarded as the corporate successor of the insured through purchase or transfer of the insured's assets; or (3) has been assigned the insured's rights in the policy") (emphasis added); see, e.g., *Holt v. Fid. Phoenix Fire Ins. Co.*, 76 N.Y.S. 2d 398, 399-400 (N.Y. App. Div. 1948) (noting that, once a fire occurred, the named insured had an accrued claim under its fire insurance policy that it could have assigned to a third party); see also *Texaco A/S, S.A. v. Commercial Ins. Co. of Newark, N.J.*, No. 90 Civ. 2722 (JFK), 1995 WL 628997, at *6 (S.D.N.Y. Oct. 26, 1995) ("[T]he rationale for respecting the no-assignment clause does not apply when liability arises from *pre-sale activity* – no-assignment clauses are designed to protect insurers from unforeseen increases in risk. When the loss occurs before the transfer, any increase in risk due to the successor's characteristics is irrelevant." (emphasis added; citations omitted)), vacated on other grounds, 160 F.3d 124 (2d Cir. 1998).

80. See, e.g., *Nat'l Am. Ins. Co. v. Jamison Agency, Inc.*, 501 F.2d 1125, 1128, 1130 (8th Cir. 1974) (holding that transfer of all assets to sole shareholder upon dissolution of corporation effectively transferred insurance coverage for pre-dissolution losses); *Ocean Accident & Guar. Corp. v. Sw. Bell Tel. Co.*, 100 F.2d 441, 443, 447 (8th Cir. 1939) (rejecting insurer's reliance on anti-assignment condition and holding that assignment of "[a]ll other property rights and assets of whatsoever nature and description" transferred to succeeding corporation the right to insurance coverage for injuries occurring before the date of conveyance); *B.S.B. Diversified Co. v. Am. Motorists Ins. Co.*, 947 F. Supp. 1476, 1479 (W.D. Wash. 1996) ("The purpose of a no-assignment clause in an insurance contract is to protect the insurer from increased liability. After the events giving rise to the insurer's liability have occurred, the insurer's risk cannot be increased by a change in the insured's identity."); *Int'l Rediscount Corp. v. Hartford Accident & Indem. Co.*, 425 F. Supp. 669,

b. CASES ADDRESSING WHETHER THE TRANSFER OF INSURANCE RIGHTS REQUIRES THE CONSENT OF THE INSURER WHERE THE INJURY OR DAMAGE WAS NOT DISCOVERED UNTIL AFTER THE TRANSFER

A number of courts, including cases decided under New York and Illinois law, have held that anti-assignment conditions do not preclude the transfer of liability insurance rights relating to bodily injuries that took place prior to, but were not discovered until after, the transfer.

For example, in *Tenneco Chemicals, Inc. v. Employers Mut. Liab. Ins. Co.*,⁸¹ the policyholder's product was injected into the claimant in 1950, and allegedly, as a result of atomic decay, unknowingly caused continuous bodily injury to the claimant until 1971, when the claimant was diagnosed.⁸² The policyholder was insured under policies issued by the defendant-insurer that were in effect from 1952 to 1960.⁸³ As a result of a corporate reorganization in 1963, the policyholder's assets were transferred to the plaintiff.⁸⁴ When the claimant filed suit against the plaintiff in 1973,

672-73 (D. Del. 1977) (agreeing with the "numerous other courts over the years" that have held that anti-assignment conditions do not apply to the transfer of insurance rights providing coverage for pre-transfer losses, stating that "it would be a mere act of caprice or bad faith for [the insurer] to take advantage of the stipulation that the transfers were subject to its consent"); *Aetna Cas. & Sur. Co. v. Valley Nat'l Bank*, 485 P.2d 837, 839 (Ariz. App. 1971) ("[T]his [anti-assignment] rule is based upon the right of the insurer to choose its insured so as to know its risks. Therefore, it is not applicable when an assignment is made by an insured after the liability-causing event has occurred." (citing several cases)); *P.R. Mallory & Co. v. Am. States Ins. Co.*, No. 54C01-0005-CP-00156, 2004 WL 1737489, at *8 (Ind. Cir. Ct. July 29, 2004) (noting that the loss at issue took place before the transfer of insurance rights); *Conrad Bros. v. John Deere Ins. Co.*, 640 N.W.2d 231, 237 (Iowa 2001) (holding that anti-assignment condition was inapplicable to transfer of chose in action for coverage for loss occurring prior to transfer, and noting that, "even if the [anti-assignment] provision had specifically prohibited post-loss assignments, it would most likely be in contravention of public policy and the general purpose of indemnity contracts"); *Massachusetts Elec. Co. v. Commercial Union Ins.*, No. 9900467B, 2005 WL 3489658, at *2 (Mass. Super. Ct. Oct. 18, 2005) (recognizing that the general rule is that anti-assignment clauses do not prevent the transfer of insurance rights for pre-transfer losses); *Egger v. Gulf Ins. Co.*, 903 A.2d 1219 (Pa. 2006) (assignment of rights to coverage as part of litigation settlement valid where loss pre-dated assignment); 3 COUCH ON INS. 3d, § 35:7 (1997) (noting that "the great majority of courts adhere to the rule that general stipulations in policies prohibiting assignments thereof except with the consent of the insurer apply only to assignments before loss, and do not prevent an assignment after loss").

81. No. 76 Civ. 809, 1977 U.S. Dist. LEXIS 16759 (S.D.N.Y. Mar. 23, 1977).

82. *Id.* at *1-2.

83. *Id.* at *2.

84. *Id.* at *8.

the plaintiff sought coverage under the policies issued by the defendant to the policyholder.⁸⁵ Rejecting the insurer's reliance on its anti-assignment condition, the court, applying New York law, held that the policyholder had an accrued claim at the time of the asset transfer in 1963 for the bodily injuries that took place prior to that time, even though no claim was asserted against the policyholder until ten years after the asset transfer:

Such [anti-assignment] clauses do not apply to an assignment of an insurance claim after the loss has occurred. This is so even if the insurance contract reads to the contrary, because the assignment of an accrued insurance claim is the same as assigning a chose in action, and contractual limitations on such assignments are contrary to the public policy of New York.

In this instance, any claim of [the policyholder] against [the defendant-insurer] accrued between 1952 and 1960, and the transfer of [the policyholder]'s assets ultimately to [the plaintiff] in 1963 occurred after any insurance claim against [the defendant-insurer] had arisen.⁸⁶

Thus, even though the insurer did not breach its policy obligations by failing to defend until the claimant filed suit in 1973, the insurance claim was deemed to have accrued when the bodily injury itself took place from 1952 through 1960, prior to the transfer of insurance assets in 1963.⁸⁷ Accordingly, the anti-assignment condition could not apply.⁸⁸

85. *Id.* at *1-2.

86. *Id.* at *7-8 (citations omitted).

87. *Id.* at *8-9.

88. *Id.*; see also *Citicorp Indus. Credit, Inc. v. Federal Ins. Co.*, 672 F. Supp. 1105, 1105-07 (N.D. Ill. 1987) (anti-assignment condition did not preclude plaintiff, which acquired the policyholder's contract rights through foreclosure, from recovering under the policyholder's indemnity policy where the losses took place prior to, but were not discovered until after, the transfer of insurance rights); *Snellman v. A.B. Dick Co.*, No. 81C3048, 1987 WL 8619 (N.D. Ill. Mar. 24, 1987) (a successor may recover under a contract for the damages suffered, but not discovered, by its predecessor prior to the transfer of the predecessor's rights under the contract to the successor); see generally *Am. Nat'l Fire Ins. Co. v. Harold Abrams, P.C.*, No. 99 C 5807, 2002 U.S. Dist. LEXIS 2577 (N.D. Ill. Feb. 19, 2002) (contrasting occurrence-based policies with claims-made policies, and noting that coverage attaches under occurrence-based policies when the occurrence causing the bodily injury or property damage takes place, not when the claim is made: "In the 'occurrence' policy, the peril insured is the 'occurrence' itself. Once the occurrence takes place, coverage attaches even though the claim may not be made for some time thereafter.

Beyond New York and Illinois, a number of courts in other jurisdictions have also held that anti-assignment conditions do not bar the transfer of liability insurance rights relating to losses that took place prior to, but were not discovered until after, the transfer. For example, in *Gopher Oil Co. v. American Hardware Mut. Ins. Co.*,⁸⁹ the policyholder engaged in activities in the 1950s and 1960s that resulted in undetected environmental property damage during the insurers' policy periods.⁹⁰ In 1973, the policyholder assigned all of its assets to the plaintiff.⁹¹ Eighteen years later, the property damage manifested, and the plaintiff was sued.⁹² The insurer refused to provide coverage based on an anti-assignment condition in its policies.⁹³ Rejecting the insurer's reliance on the anti-assignment conditions, the court held that it would follow the "great majority of courts" that had concluded that anti-assignment conditions do not bar the transfer of insurance rights for liability coverage for events that took place prior to the transfer:

The purpose of a non-assignment clause is to protect the insurer from an increase to the risk it has agreed to insure. But when events giving rise to an insurer's liability have already occurred, the insurer's risk is not increased by a change in the insured's identity.⁹⁴

Thus, because there could not be a material increase in risk to the insurer with respect to tortious conduct that had already taken place, the court ruled that the anti-assignment condition did not apply to this transfer of liability insurance rights for property damage that was ongoing, but not yet discovered, at the time of the transfer.⁹⁵

Similarly, in *Total Waste Management Corp. v. Commercial Union Insurance Co.*,⁹⁶ the policyholder was insured under a general liability

[Whereas] in the "claims made" policy, it is the making of the claim which is the event and peril being insured") (quoting *Nat'l Union Fire Ins. Co. v. Bauman*, No. 90 C 0340, 1991 U.S. Dist. LEXIS 18668, at *5 (N.D. Ill. Jan. 2, 1992)).

89. 588 N.W.2d 756 (Minn. App. 1999).

90. *Id.* at 761-62.

91. *Id.* at 761, 763.

92. *Id.* at 761.

93. *Id.* At 761-762.

94. *Id.* at 763.

95. *Gopher Oil*, 588 N.W.2d at 763.

96. 857 F. Supp. 140 (D.N.H. 1994).

policy issued by the defendant with a policy period ending in 1984.⁹⁷ In 1988, the policyholder sold certain assets to the plaintiff.⁹⁸ A third party subsequently sued the plaintiff for property damage that had occurred, but had not been discovered, prior to the asset sale.⁹⁹ The insurer denied the plaintiff's claim that it had succeeded to the policyholder's liability coverage rights.¹⁰⁰ The court ruled against the insurer, holding that the anti-assignment condition did not preclude the plaintiff's right to liability coverage for property damage that had been caused by the policyholder and that had taken place during the insurer's policy period:

Some of the damage or loss caused by [the policyholder] to [the third party]'s property allegedly occurred during the term of [the insurer]'s policy and prior to [the policyholder]'s transfer of assets. [The insurer]'s risk is therefore no greater than when the policy "covers only the risk it evaluated when it wrote the policy." If [the plaintiff] is found to be the corporate successor to [the policyholder], [the insurer]'s liability on the insurance contract to [the policyholder] would be limited to the terms and date of the policy.¹⁰¹

In the context of asbestos-related bankruptcy plans, several courts have confirmed that insurance rights of a debtor-policyholder may be transferred to a trust to fund the payment not only of pending asbestos claims, but also of future asbestos claims not yet asserted, despite the objections of the debtor's insurers based on the anti-assignment conditions in their policies.¹⁰²

97. *Id.* at 154.

98. *Id.* at 143 n.2.

99. *Id.* at 142.

100. *Id.* at 145.

101. *Id.* at 153 (quoting *N. Ins. Co. of New York v. Allied Mut. Ins. Co.*, 955 F.2d at 1358); *see also* *Wolkerstorfer Co. v. Bituminous Cas. Co.*, No. C0-93-12712, slip op. at 8-11 (Minn. 10th Dist. May 19, 1994) (holding that transfer of assets from a partnership to a corporation transferred rights to liability coverage for environmental property damage that had taken place prior to the transfer but which was not discovered until years after the transfer); *Sharon Steel Corp. v. Aetna Casualty & Surety Co.*, 931 P.2d 127, 139 n.15 (Utah 1997) (holding that an insurer's consent was not needed to transfer insurance rights covering liability for ongoing, but undiscovered, property damage from the policyholder to a liquidating trust as part of the policyholder's dissolution).

102. *See In re ACandS, Inc.*, 311 B.R. 36, 41 (Bankr. D. Del. 2004) ("[B]ecause an insured's right to proceeds vests at the time of the loss giving rise to the insured's liability, restrictions on an insured's right to assign its proceeds are generally rendered void."

c. POTENTIAL INSURER RESPONSES

Insurers often proffer a series of arguments to support their position that insurance rights may not be transferred in the face of an anti-assignment provision without their consent, including the following arguments. Specifically, insurers frequently argue:

1. That a policyholder has not suffered a “loss” under the policy until the insurer has breached its duty to defend or indemnify, and therefore that no “loss” could have taken place prior to the execution of the asset purchase agreement where the bodily injury or property damage was not discovered until after that time;
2. That insurance rights can only be transferred “by operation of law”;
3. That various cases should be read to support the conclusion that the anti-assignment conditions apply to the transfer of historical insurance assets;
4. That the decisions in *Henkel* and related cases represent the better reasoned view.

As discussed below, Successor Insureds may raise various hurdles in an attempt to defeat these insurer arguments.

1. The Successor Insured Position: Insurance Rights for Pre-Transfer Injuries or Damage May Be Transferred Regardless of Whether or Not the Insurer Has Breached Its Duties by the Time of the Transfer

As discussed above, a number of courts have held that an anti-assignment condition does not ordinarily preclude the transfer of insurance

(quoting *Cont. Cas. Co. v. Diversified Indus., Inc.*, 884 F. Supp. 937, 946 (E.D. Pa. 1995)); *see also* *In re Combustion Eng'g, Inc.*, No. 03-10495(JKF), Transcript of Bench Opinion at 145-46 (D. Del., July 31, 2003) (confirming bankruptcy plan that assigned insurance proceeds to trust over the objections of debtor's insurers based on anti-assignment conditions, stating that “[a]ssignment of a right to receive proceeds does not change any risk that was insured against.”) (*vacated on other grounds*, 391 F.3d 190, 218-19 (3d Cir. 2004)) (declining to reach merits of insurers' argument that assignment of proceeds violated anti-assignment conditions in policies).

rights providing liability coverage for injuries or damage that was ongoing, but undiscovered, at the time of the transfer. Insurers often try to avoid that conclusion by asserting that, for such injuries or damage, the relevant loss did not occur until after the execution of the asset purchase agreement. The insurers base this contention on the theory that a policyholder does not suffer a “loss” until an insurer has failed to defend or indemnify it. To illustrate, in cases involving asbestos, environmental, and other latent bodily injury and property damage claims that were not filed until after an asset sale took place, the insurers may argue that they did not fail to defend or indemnify the policyholder before the asset sale, and hence that no policyholder incurred a “loss” until after the asset purchase agreement was executed. Thus, the argument goes, there were no insurance rights or choices in action to transfer to the purchaser at the time of the asset sale.

The decisions discussed above cast doubt on this pro-insurer argument. In each of those cases, the underlying injury or damage had not yet been discovered at the time of transfer of the insurance asset, and no suit had been filed against the party seeking insurance coverage. Accordingly, no claim had been made for the insurer to deny before the transfer. Under the pro-insurer argument, no “loss” – i.e., rejection of the request for a defense or indemnity – had occurred before the applicable transfer; nonetheless, the courts concluded in each case that the anti-assignment condition was inapplicable.

The decisional law discussed above thus appears to undercut the pro-insurer position that “loss” for purposes of analyzing the applicability of an anti-assignment condition relates to when the insurer decides to deny a claim for coverage. Rather, the view of these courts is that the relevant “loss” occurs not when the insurer denies coverage, but rather when the event giving rise to the liability takes place, e.g., when the bodily injury or property damage occurs.

Notwithstanding such cases, *Henkel* and its related cases, discussed below, provide support for the insurers’ position. In an effort to build further support, insurers may take relatively novel positions on the interpretation of decisional law to bolster their position that liability insurance rights cannot be transferred until the insurer has failed to defend or indemnify the insured. However, Successor Insureds may contend that the cases that insurers typically rely upon do not provide the necessary foundation for that position:

*Bronx Entertainment v. St. Paul's Mercury Ins. Co.*¹⁰³ – In this decision, the named insured assigned its insurance claim for business interruption damages to the plaintiff. Even though the policy at issue contained an anti-assignment condition, the court held that the plaintiff could maintain an action against the insurer for these pre-assignment business interruption damages.¹⁰⁴ The court held that the plaintiff could not recover for its own business interruption losses suffered after the assignment at issue, absent the insurer's consent.¹⁰⁵

*Service Adjustment Co. v. Underwriters at Lloyd's, London*¹⁰⁶ – Consistent with the majority rule discussed above, this decision, which involves a fire loss under a fire insurance policy, stands for the simple proposition that “[a]n insured's claim under a policy may be assigned after the loss.”¹⁰⁷ The decision does not address situations in which the loss took place prior to the transfer, but was not discovered until after the transfer.

*Loyola Univ. Med. Center v. Med Care HMO*¹⁰⁸ – In this decision, the court held that an anti-assignment condition did not apply to the transfer of medical insurance benefits where the injury had taken place before the transfer, even though the medical costs for which the insurance policy would provide reimbursement had not yet been incurred.¹⁰⁹ Even though the medical insurance policy would have no obligation to indemnify the policyholder until it incurred medical costs, the court found that the relevant “loss” was

103. 265 F. Supp. 2d 359 (S.D.N.Y. 2003).

104. *Id.* at 363 (“Of course Plaintiff may maintain an action for [transferor's] losses that accrued as of the date of the assignment.”)

105. *Id.*

106. 562 N.E.2d 1046 (Ill. App. Ct. 1990).

107. *Id.* at 1049.

108. 535 N.E.2d 1125 (Ill. App. Ct. 1989).

109. *Id.* at 1129.

the incidence of injury and not the payment of medical costs. Accordingly, because the loss occurred before the assignment, the assignment was not precluded by the anti-assignment condition.¹¹⁰

In sum, as discussed above, a number of courts have held that an anti-assignment condition does not apply to the transfer of liability insurance rights for coverage for injuries or damage taking place prior to the transfer, even where such injuries or damage have not been discovered prior to the transfer. The insurers' contention that an assignor does not have any insurance choices in action to transfer until it has been the victim of a breach by the insurer of its duty to defend or indemnify is not consistent with this decisional law.

2. The Successor Insured Position: To Survive
Application of an Anti-Assignment Condition, a
Transfer of Insurance Rights Is Not Required to Occur
"by Operation of Law"

Insurers often contend that, where a policy contains an anti-assignment condition and the insurer's consent has not been obtained, coverage rights can only be transferred if, among other requirements, that transfer occurs "by operation of law." Under this approach, insurers contend that neither an asset purchase, a stock purchase, nor an assignment in connection with a corporate dissolution constitutes a transfer "by operation of law." As a result, such insurers argue, the transferee in question cannot be the successor to the transferor's insurance rights at issue.

This particular pro-insurer position has substantial weaknesses. Among other things, no requirement that the transfer of insurance rights must be accomplished "by operation of law" can be gleaned from much of the decisional law.¹¹¹ Successor Insureds may argue that no basis exists to

110. *Id.* ("What [the policyholder] assigned was her present conditional right to the insurance proceeds. A valid assignment of a conditional right is enforceable in equity." (citations omitted)).

111. By way of example, although the courts in each of the following cases held that insurance rights had effectively transferred, not one of the cases involved a transfer by operation of law: *Citicorp Indus. Credit, Inc. v. Fed. Ins. Co.*, 672 F. Supp. 1105, 1105-07 (N.D. Ill. 1987); *Snellman v. A.B. Dick Co.*, No. 81C3048, 1987 WL 8619 (N.D. Ill. Mar. 24, 1987); *Tenneco Chemicals, Inc. v. Employers Mut. Liab. Ins. Co.*, No. 76 CIV 809, 1977 U.S. Dist. LEXIS 16759 (S.D.N.Y. Mar. 23, 1977); *Gopher Oil Co. v. American*

impose such a requirement and that so doing would run afoul of the case law supporting their position.

3. The Successor Insured Position: Cases Relied Upon by Insurers Do Not Support the Insurers' Position

In addition to *Henkel*, insurers often assert that a number of cases hold that anti-assignment conditions preclude the transfer of insurance rights in corporate transactions other than mergers. However, Successor Insureds may argue that these decisions do not support the insurers' position:

*Employers Ins. of Wausau v. Duplan Corp.*¹¹² – Apparently contradicting the insurers' suggestion that coverage can transfer only through a merger, this decision expressly confirms that an entity that is not a named insured may still invoke rights under an insurance policy not only as a result of a merger, but also when the entity “is legally regarded as the corporate successor of the insured through purchase or transfer of the insured's assets; or . . . has been assigned the insured's rights in the policy.”¹¹³ The party seeking coverage in *Wausau* was denied coverage because it had not purchased the named insured's assets, obtained an assignment from the named insured, *or* merged with the insured.¹¹⁴

*Home Ins. Co. v. Service Am. Corp.*¹¹⁵ – In this decision, the defendant was initially a subsidiary of the named insured, and thus initially was covered under a policy that insured the named insured and its “subsidiaries.”¹¹⁶ When the defendant was sold to a third party, it ceased to be a subsidiary of the

Hardware Mut. Ins. Co., 588 N.W.2d 756, 764 (Minn. App. 1999); *Wolkerstorfer Co. v. Bituminous Cas. Co.*, No. C0-93-12712, slip op. at 8-11 (Minn. 10th Dist. May 19, 1994); *Sharon Steel Corp. v. Aetna Casualty & Surety Co.*, 931 P.2d 127, 139 (Utah 1997); *see also supra* Sections III, IV.

112. No. 94 Civ. 3143(CSH), 1999 WL 777976 (S.D.N.Y. Sept. 30, 1999).

113. *Id.* at *32.

114. *Id.*

115. 662 F.Supp. 964 (N.D. Ill. 1987).

116. *Id.* at 965.

named insured, and thus ceased to be insured under the policy for any losses that arose after the sale.¹¹⁷ Consequently, when the defendant suffered a fire loss after the sale, the court found no coverage for the defendant's fire loss.¹¹⁸

*Butera v. Attorneys' Title Guar. Fund, Inc.*¹¹⁹ – This decision involves an entirely different form of insurance from standard-form liability policies – title insurance – that has unique policy language not found in standard-form liability insurance policies.¹²⁰ Specifically, the title insurance at issue in *Butera* provided coverage for the “insured,” defined to mean “the [named] insured [and] . . . those who succeed to the interest [in the real property at issue] of such insured by operation of law as distinguished from purchase including, but not limited to, heirs, distributees, devisees, survivors, personal representatives, next of kin, or corporate or fiduciary successors.”¹²¹ Because the plaintiffs acquired the real property at issue through a “purchase,” the court held that they did not qualify as insureds under this definition.¹²² As the court noted, “Title insurance is an unusual type of insurance. It is not a recurring policy: there is a single premium, and the policy remains outstanding forever to protect the property owner.”¹²³ In short, because of the substantial differences in the type of policy at issue, the policy language, and the risks covered by the policy, *Butera* may not be applicable more generally to cases in which liability insurance rights are being transferred.

117. *Id.*

118. *Id.* at 968.

119. 747 N.E.2d 949 (Ill. App. Ct. 2001).

120. *Id.* at 950.

121. *Id.* at 951.

122. *Id.* at 954.

123. *Id.*

*Holt v. Fidelity Phoenix Fire Ins. Co.*¹²⁴ – In this decision, the court agreed that, once a fire occurred, the named insured had an accrued claim under its fire insurance policy that it could have assigned to a third party.¹²⁵ Other than recognizing that insurance rights may be assigned without the insurer's consent where the loss has taken place prior to the assignment, this decision stands for the relatively commonplace proposition that an assignee of a business interruption rider to a fire policy may not recover for its own business interruption losses that were incurred after the assignment, absent the insurer's consent.¹²⁶

*Bronx Entertainment v. St. Paul's Mercury Ins. Co.*¹²⁷ – Similar to the facts in *Holt*, this decision involved a claim by the named insured under a business interruption policy.¹²⁸ Shortly after suffering property damage, the named insured assigned its insurance claim to the plaintiff.¹²⁹ Even though the policy contained an anti-assignment condition, the court confirmed that the plaintiff could maintain an action for these pre-assignment damages against the insurer.¹³⁰ As in *Holt*, the court held that the plaintiff could not recover for its *own* business interruption losses suffered *after* the assignment at issue, absent the insurer's consent.¹³¹

*Carle Place Plaza Corp. v. Excelsior Ins. Co.*¹³² – Similar to the decision in *Holt*, this decision also stands for the proposition that an assignee may not recover under a fire insurance

124. 76 N.Y.S.2d 398 (N.Y. App. Div. 1948).

125. *Id.* at 399.

126. *Id.* at 399-400.

127. 265 F.Supp. 2d 359 (S.D.N.Y. 2003).

128. *Id.* at 361.

129. *Id.* at 360.

130. *Id.* at 363.

131. *Id.*

132. 534 N.Y.S.2d 397 (N.Y. App. Div. 1988).

policy for a fire loss that takes place after the assignment, absent consent of the insurer.¹³³

*EM Indus. Inc. v. Birmingham Fire Ins. Co.*¹³⁴ – This decision cites favorably the decision in *Ocean Accident & Guar. Corp. v. Southwestern Bell Tel. Co.*,¹³⁵ which held that insurance benefits may be transferred without the insurer's consent despite the presence of an anti-assignment condition in the policy where the injury or damage has taken place prior to the transfer.¹³⁶ The court in *EM Indus.* stated that the plaintiff's insurer had "failed to establish its alternative contentions that [another insurer] is obligated to the plaintiff and therefore to it under an assignment theory (see, *Ocean Acc. & Guar. Corp. v. Southwestern Bell Tel. Co.*, 100 F.2d 441, cert. denied, 306 U.S. 658 [and cases cited therein]) or under a successor-enterprise liability theory, since there was no merger of companies as a result of the [purchase agreement] (see, *Schumacher v. Richards Shear Co.*, 59 N.Y.2d 239)."¹³⁷ In other words, insurance rights could have transferred either by merger or by a non-merger transaction, as in *Ocean Accident*.¹³⁸

*Insurance Co. of N. Am. v. Snyder Moving & Storage, Inc.*¹³⁹ – The court in *Snyder* noted that the seller in an asset sale may be permitted to sell its rights to insurance benefits despite an anti-assignment condition: "“This [non-assignment] rule is based upon the right of the insurer to choose its insured so as to know its risks. Therefore, it is not applicable when an assignment is made by an insured after the liability-causing event has occurred. . . . In such a case the general rule is that

133. *Id.* at 398.

134. 529 N.Y.S.2d 121 (N.Y. App. Div. 1988).

135. 100 F.2d 441 (8th Cir.1939), cert. denied, 306 U.S. 658 (1939).

136. *Id.* at 444-45.

137. *EM Indus.*, 529 N.Y.S.2d at 123.

138. *Id.*

139. 52 Fed. Appx. 899 (9th Cir. 2002).

the assignment is not of the policy itself, but of a claim under, or a right of action on, the policy.”¹⁴⁰

*Federal Ins. Co. v. Purex Indus., Inc.*¹⁴¹ – In this decision, the court denied an insurer’s motion for summary judgment based on an anti-assignment condition because the insurer had failed to carry its burden of showing that the condition applied. The court did not have occasion to rule whether insurance assets could be transferred only in a merger.¹⁴²

*Red Arrow Prods. Co. v. Employers Ins. of Wausau*¹⁴³ – In this decision, the court rejected the asset purchaser’s claim to coverage under the seller’s policies because the parties agreed that the insurance rights were not part of the assets conveyed in the asset purchase agreement.¹⁴⁴ Unable to argue that there had been an express transfer of the seller’s insurance rights, the buyer relied entirely on the *Northern Insurance* line of cases to assert that, because it had CERCLA liability for the actions of the seller, it should be entitled to access the seller’s insurance by operation of law.¹⁴⁵ The court rejected the reasoning of the *Northern Insurance* line of cases because “[t]he [public] policies driving the product-line successor liability rule, however, are clearly not at play here [in a case involving CERCLA liability].”¹⁴⁶

140. *Id.* at 903-04 (quoting *Aetna Cas. & Sur. Co. v. Valley Nat. Bank of Ariz.*, 485 P.2d 837, 839 (1971)). Having said that, the court went on to deny that the plaintiff had acquired the insurance benefits of the seller on the grounds that the asset purchase agreement identified the specific assets that were being transferred, and insurance was not among them. *Id.*

141. 972 F. Supp. 872 (D.N.J. 1997).

142. *Id.* at 899-90.

143. 607 N.W.2d 294 (Wis. Ct. App. 2000).

144. *Id.* at 299.

145. *Id.* at 299-300.

146. *Id.* at 302-03.

*Muslin v. Frelinghuysen Livestock Managers, Inc.*¹⁴⁷ – In this decision, a racehorse mortality policy contained an anti-assignment condition and, in addition, expressly provided that transfer of any interest in the horse at issue would result in the voiding of the policy. The policyholder orally transferred the horse to third parties. As a result, the court held that the policy was void as of the time of the transfer. Consequently, when the horse died after the transfer, the new owners of the horse could not recover under the mortality policy.¹⁴⁸ Because *Muslin* involves a type of policy and policy language not at issue in standard-form liability insurance policies, the decision may be viewed by courts as irrelevant in cases involving the assignment of liability insurance rights. At best, *Muslin* stands for the proposition that, where an insurance policy containing an anti-assignment condition was assigned without the insurer's consent, the policy does not provide coverage to the assignee for losses incurred *after* the assignment.

In sum, Successor Insureds have a number of arguments that they may rely on to attempt to distinguish the cases often cited by insurers seeking to establish the broad applicability of anti-assignment provisions.

4. Henkel and Cases Involving Retroactive Liability

a. The *Henkel* Decision

While the decisional law discussed above may not provide a strong foundation of support to insurers seeking broad enforcement of anti-assignment provisions, the *Henkel* decision does support the insurers' usual position that anti-assignment conditions bar the transfer of coverage rights without their consent. However, the *Henkel* decision may be vulnerable to several counter-arguments that Successor Insureds may raise.

147. 777 F.2d 1230 (7th Cir. 1985).

148. *Id.* at 1232.

i. The Successor Insured Position: The
Henkel Decision Would Lead to
 Absurd and Unfair Consequences

From the Successor Insured's perspective, the *Henkel* decision should not be followed because requiring insurer consent to transfer insurance proceeds for undiscovered losses that took place prior to the transfer would lead to unreasonable consequences. On this view, an insurer has no incentive whatsoever to consent to a request by the policyholder to assign insurance proceeds. Indeed, an insurer arguably has an incentive to *not* consent, in the hope that the policyholder would go forward with the asset sale anyway, thereby giving the insurer an argument that it is free of any coverage obligation for pre-assignment losses.

The policyholder seemingly is then left with a Hobson's choice – abandon the asset sale and its attendant benefits or, under *Henkel*, cause the insurance rights that it had already paid premiums to obtain to vanish, giving the insurer a windfall and likely making the asset sale much less attractive to the buyer, who then may be risking the assumption of liabilities without insurance to pay for them. Under the Successor Insured view, either result is against public policy.

First, two entities that have decided that it is in each of their respective economic interests to enter into an asset sale should not be dissuaded from doing so because insurers, who have already been paid premiums to cover a certain risk, can escape that risk by refusing to consent to the assignment. Putting this kind of power in the hands of insurance companies to deter legal and beneficial commerce benefits no one except those insurance companies.

Second, from a Successor Insured's perspective, insurers would receive an undeserved windfall as a result of the *Henkel* approach in those cases where the contracting parties went ahead with the asset sale. In contrast, the Successor Insured Position avoids such windfalls by permitting the transfer of coverage for pre-transfer losses on the rationale that such a transfer does not increase the risk that the insurers agreed to accept and for which they were paid substantial premiums.

Third, Successor Insureds may argue that the *Henkel* decision is at odds with the well-settled principle of insurance law that ambiguous policy language should not be construed to forfeit coverage.¹⁴⁹

149. See, e.g., *A.D. Desmond Co. v. Jackson Nat'l Life Ins. Co.*, 585 N.E.2d 1120, 1122 (Ill. App. Ct. 1992) ("Insurance forfeitures are not favored as insurance serves

Fourth, according to Successor Insureds, the *Henkel* decision runs afoul of the general rule that anti-assignment conditions are to be construed narrowly, against the party seeking to prohibit the assignment.¹⁵⁰ Therefore, the Successor Insured's Position goes, because typical anti-assignment conditions do not unambiguously apply to transfers of insurance rights relating to losses that took place prior to the transfer, the *Henkel* court should have construed the anti-assignment condition at issue there against the insurer and in a manner that preserved, rather than forfeited, coverage.

In sum, the Successor Insured Position posits that the *Henkel* decision, if followed, would result in unfair and economically detrimental consequences. Under this Position, because courts are to avoid interpreting insurance policy or other contractual provisions in a manner that leads to absurd consequences, courts should not construe the anti-assignment conditions to bar the transfer of liability insurance rights where the losses already took place, or began to take place, prior to the transfer.¹⁵¹

ii. The Successor Insured Position: The
Henkel Decision Incorrectly Found an
Increased Risk to the Insurer

In addition to leading to unfair consequences, Successor Insureds may claim that the *Henkel* court's analysis is flawed because it incorrectly concluded that the transfer of insurance rights relating to losses that had already taken place would subject the insurer to an increased risk. The

important purposes in contemporary society, and courts should be quick to find facts which support coverage.”); *Brynildsen v. Ambassador Ins. Co.*, 274 A.2d 327, 329 (N.J. Super. Law Div. 1971) (“This court is in accord with the general principle of the law of insurance that forfeitures are not looked upon with favor, and is disposed to avoid forfeiture if by reasonable interpretation it can do so.”).

150. *See, e.g., Elzinga & Volkers, Inc. v. LSSC Corp.*, 838 F. Supp. 1306, 1313 (N.D. Ind. 1993) (“[B]ecause the [anti-assignment] clause is a restriction on alienation, it must be strictly construed against the party urging the restriction.”); *First Bank & Trust v. Novak*, 747 P.2d 850, 855 (Kan. Ct. App. 1987) (“A restriction against assignment is a restraint on alienation, and as such it is strictly construed against the party urging the restriction”).

151. *Cross Armored Carrier Corp. v. Valentine*, 268 N.Y.S.2d 792, 797-98 (N.Y. Supr. Ct. 1966) (“Resort to a literal construction may not be had where the result would be to thwart the obvious and clearly expressed purpose which the parties intended to accomplish or where such a construction would lead to an obvious absurdity or place one party at the mercy of another.” (citations omitted)); *U.S. Fire Ins. Co. v. Hartford Ins. Co.*, 726 N.E.2d 126, 128 (Ill. App. Ct. 2000) (“[A] strained, forced, unnatural, or unreasonable construction, or one which would lead to an absurd result must be adopted.”)

principal basis for the court's conclusion was that, where the assignor still exists or can be revived, the insurer may be required to "face[] the dilemma" whether to provide coverage to the assignor, the assignee, or both if a dispute arises over the existence and scope of the assignment.¹⁵² Successor Insureds may argue that, contrary to the court's suggestion, such a circumstance would not subject the insurer to any risk that is any different from the risks that the insurers agreed to accept.

First, insurers are faced with the potential for invalid coverage claims every day. Whether it is a request for coverage by a company that previously assigned away its insurance rights or a request for coverage by an insured whose claim falls within an exclusion, the business of insurers is to apply their policies to the facts and pay those claims that are valid. The fact that an insurer must distinguish valid claims from invalid claims does not constitute an increase in the insured risk, but rather is a part of that insurer's normal business operations.

Second, the law and applicable rules provide procedural vehicles through which the insurers may resolve any uncertainties regarding whether coverage exists for a claim. If an insurer cannot determine whether a claim is covered or excluded, or whether the entity requesting coverage is insured or not, the insurer may reserve its rights and commence a declaratory judgment action that will clarify its obligations. Alternatively, where more than one entity claims a right to the same set of insurance proceeds, the insurer may commence an interpleader action and/or pay the proceeds into an account with the court, with the proceeds to be paid to the entity that succeeds in demonstrating that it is entitled to them.¹⁵³ These procedural mechanisms ensure that the insurer will not be required to pay any more money than it is obligated to pay under its insurance policy.

Third, depending on the circumstances, the insurers may be obligated to provide coverage to both entities seeking coverage. Insurers routinely provide coverage, for instance, to multiple members of the same corporate family. Each claim for coverage by competing claimants must be evaluated on its own merits.

152. *Henkel Corp. v. Hartford Accident & Indem. Co.*, 62 P.3d 69, 75-76 (Cal. 2003).

153. *See, e.g., Krauss v. Central Ins. Co.*, 40 N.Y.S.2d 736, 738 (N.Y. Supr. Ct. 1943) (explaining that in a dispute between a policyholder and an entity that alleged that the policyholder had assigned its interest in insurance proceeds to the entity, the insurer deposited the insurance proceeds with the court, to be distributed to whichever claimant succeeded in demonstrating its entitlement).

Thus, under the Successor Insured view, the fact that an assignor and an assignee may both claim an entitlement to insurance proceeds does not necessarily “increase the risk” to the insurer. An insurer may pay the party that it believes possesses a valid claim, or a court may determine which party has the valid claim. What the insurer should not be permitted to do, according to Successor Insureds, is refuse to pay either claim because of the possible occurrence of the other. This is particularly true when the lack of increased risk to the insurer is weighed against the consequences to an asset purchaser of finding that, contrary to its reasonable expectations, it did not obtain any insurance rights after all. In sum, Successor Insureds may strongly contest the court’s finding in *Henkel* that assignment of rights to insurance proceeds increases the risk to the insurer.

iii. The Successor Insured Position: The *Henkel* Decision Incorrectly Requires a Breach by the Insurer Before an Interest in the Policy May Be Assigned

The *Henkel* decision also is based on the premise that the insurer must have breached the policy before the policyholder has a right that may be assigned. Without significant analysis, the *Henkel* court concluded that the assignor there did not have an assignable chose in action for breach of the insurance policy at the time of the assignment because the underlying asbestos claimants had not yet asserted any claims; consequently, no claim had been made yet to the insurer and no chose in action for breach of contract existed that could be assigned.¹⁵⁴

Successor Insureds will argue that the *Henkel* court’s holding that the insurer must first breach the policy before the policyholder has accrued any assignable rights under the policy is contrary to the rulings of the numerous courts discussed above that have held that the policyholder possesses a chose in action at the time that the underlying claimant suffers bodily injury (or property damage).¹⁵⁵ Those cases did not require a breach of the

154. *Henkel*, 62 P.3d at 75.

155. *See supra* Parts IV.A-IV.C.1. While these courts have found that the claim or chose in action has arisen at the time that the loss takes place and therefore may be transferred in a corporate transaction, the claim will typically not be considered to have accrued for purposes of the statute of limitations, because different considerations and public policies are implicated in the analysis of whether the statute of limitations has expired in a given case. Analysis of statute of limitations issues are outside the scope of this article.

policy by the insurer – only that the loss in the underlying case occurred prior to the transfer.

Further, even assuming *arguendo* that the policyholder does not possess an accrued insurance claim at the time of the assignment, it arguably does possess a *conditional* right under the policies. Such conditional rights have been found by certain courts to be assignable.¹⁵⁶

From the Successor Insured's perspective, just as anti-assignment conditions do not apply to accrued insurance claims relating to losses that took place prior to the assignment, such conditions do not bar the assignment of conditional rights to insurance coverage. As an example in support of this position, in *Loyola University Medical Center v. Med Care HMO*,¹⁵⁷ an insured possessed an insurance contract with a health maintenance organization (HMO) that entitled her to reimbursement for payments made for medical treatment covered under the contract.¹⁵⁸ Prior to receiving treatment or paying any medical expenses for a medical condition that the insured sustained, the insured assigned her rights to proceeds under the medical insurance contract to the hospital that would be providing her treatment.¹⁵⁹ After providing treatment, the hospital sought payment from the HMO. However, the HMO denied coverage on the grounds that the insured's assignment of the insurance proceeds violated an anti-assignment clause. Specifically, the HMO argued that the medical insurance contract provided indemnity for the cost of medical services and, since the insured had not received any medical services at the time of the assignment, the insured had no chose in action to assign to the hospital.¹⁶⁰ Rejecting this argument, the court held that the anti-assignment clause did not preclude the transfer of the insured's conditional right to insurance proceeds:

156. See, e.g., RESTATEMENT (SECOND) OF CONTRACTS, § 320 ("The fact that a right . . . is conditional on the performance of a return promise or is otherwise conditional does not prevent its assignment before the condition occurs."); *Great Am. Indem. Co. v. Allied Freightways, Inc.*, 91 N.E.2d 823, 824-25 (Mass. 1950) (following the "great weight of authority" recognizing the validity of a present assignment of anticipated benefits under a contract that are conditioned on an event that may or may not happen in the future); *Costanzo v. Costanzo*, 590 A.2d 268, 271 (N.J. Super. Law Div. 1991) (confirming that injured victim could assign his conditional right to settlement proceeds even though his tort claim had not settled and may have never settled).

157. 535 N.E.2d 1125 (Ill. App. Ct. 1989).

158. *Id.* at 1129.

159. *Id.* at 1126-27.

160. *Id.* at 1128-29 & n.2.

What [the insured] assigned was her present conditional right to the insurance proceeds. A valid assignment of a conditional right is enforceable in equity. Hence, the assignment attaches to each installment of money “to become due” under an existing contract as it becomes due and payable to the assignor.¹⁶¹

Accordingly, Successor Insureds will argue that, once a claimant has suffered injury or damage, the policyholder has an accrued liability insurance claim under its policies in effect during the time of the injury or damage, or, at a minimum, the policyholder has a conditional right to proceeds under those policies. Either way, under the Successor Insured Position, the claim or right is assignable and such an assignment would not violate an anti-assignment condition.

Moreover, for the reasons discussed above, Successor Insureds may contend that the *Henkel* decision is erroneous, and hence courts should follow the cases holding that anti-assignment conditions do not apply to the transfer of liability insurance rights relating to losses that took place prior to the transfer, including losses that are not discovered until after the transfer.

b. Cases Involving Retroactive Liability

Insurers also typically rely heavily on two cases, (1) *Quemetco Inc. v. Pacific Auto. Ins. Co.*,¹⁶² and (2) *Century Indem. Co. v. Aero-Motive Co.*,¹⁶³ involving an asset purchaser’s ability to access the seller’s insurance policies for environmental liability imposed retroactively by statutes passed subsequent to the date of the asset purchase.¹⁶⁴ In each of these cases, according to the insurers’ perspective, the asset seller allegedly could not have had a right to insurance proceeds at the time of the asset sale because there was no basis for liability at that time.¹⁶⁵ It was not until years after each respective transaction, however, that statutes were passed. These

161. *Id.* at 1129 (citations omitted); see also *Robert S. Pinzur, Ltd. v. Hartford*, 511 N.E.2d 1281, 1286 (Ill. App. Ct. 1987) (confirming that a policyholder may assign its present conditional right to proceeds that had not yet accrued, though ultimately finding no assignment because the assignor received no consideration), *appeal denied*, 515 N.E.2d 126 (Ill. 1987).

162. 29 Cal. Rptr. 2d 627 (Cal. Ct. App. 1994).

163. 318 F.Supp.2d 530 (W.D. Mich. 2003).

164. *Quemetco*, 29 Cal. Rptr. 2d at 628; *Aero-Motive*, 318 F. Supp. 2d at 532.

165. See *Quemetco*, 29 Cal. Rptr. 2d at 629-30; *Aero-Motive*, 318 F. Supp. 2d at 537.

statutes retroactively imposed environmental liability on the asset seller (and the asset purchasers) such that a right to insurance proceeds could exist; even though the asset seller had no right to insurance proceeds at the time of the transaction and no right to insurance proceeds could have been conveyed to the asset purchaser. The courts, agreeing with this position, held that no insurance proceeds transferred to the asset purchasers.¹⁶⁶

For instance, in *Quemetco*, the buyer contended that it had acquired the seller's insurance choses in action in the asset purchase agreement. The court cited with approval the decisions in *Ocean Acc. & Guar. Corp. v. Sw. Bell Tel. Co.*,¹⁶⁷ and *Greco v. Oregon Mut. Fire Ins. Co.*,¹⁶⁸ in which the courts held that anti-assignment conditions did not preclude the transfer of insurance proceeds for losses that took place prior to the transfer.¹⁶⁹ However, because of the retroactive nature of CERCLA, the court held that no loss or damage existed at the time of the sale, and thus no insurance proceeds could have been purchased by the asset buyer.¹⁷⁰

Similarly, in *Aero-Motive*, in 1972, the named insured sold assets, including a manufacturing plant, to the defendant, and expressly assigned two insurance policies to the defendant.¹⁷¹ In the early 1990s, the defendant discovered contamination at the site where the plant was located, and was then required to take remedial action by the Michigan Department of Environmental Quality.¹⁷² Like the court in *Quemetco*, the court in *Aero-Motive* confirmed that "an anti-assignment clause will not be enforced where a loss occurs before the assignment, because in that situation the assignment of the claim under the policy is viewed no differently than any other assignment of an accrued cause of action."¹⁷³ Moreover, the court noted that the "majority rule" was that "an insurer's responsibility under a liability policy accrues at the time the complainant suffers damage rather than at the time of the negligent act."¹⁷⁴ Nevertheless, because there was no damage upon which liability could be imposed until decades after the asset sale, the court concluded that there was no right to insurance proceeds at the time of the sale, and thus the asset

166. See *Quemetco*, 29 Cal. Rptr. 2d at 632; *Aero-Motive*, 318 F. Supp. 2d at 538-39.

167. 100 F.2d 441 (8th Cir. 1939).

168. 12 Cal. Rptr. 802 (Cal. Ct. App. 1961).

169. *Ocean Acc. & Guar. Corp.*, 100 F.2d at 447; *Greco*, 12 Cal. Rptr. at 806.

170. *Quemetco*, 29 Cal. Rptr. 2d at 632.

171. *Aero-Motive*, 318 F. Supp. 2d at 532-33.

172. *Id.* at 533.

173. *Id.* at 539 (citations omitted).

174. *Id.* at 540.

purchaser did not acquire any rights to coverage for the environmental liability at issue.

From the Successor Insured's perspective, the decisions in *Quemetco* and *Aero-Motive* are flawed because, while these courts correctly acknowledged and agreed with the cases that anti-assignment conditions generally do not bar the transfer of coverage for pre-transfer losses, these courts failed to properly apply this conclusion. While the courts were focused on the passage of statutes after the transfers in question that sought to impose retroactive liability, the courts ignored the fact that the common law typically provides a basis, such as under the laws of trespass and nuisance, for imposing liability for environmental property damage. Thus, as subsequent courts have found, Successor Insureds may assert that the courts were arguably mistaken in concluding that there was no right to insurance proceeds at the time of the transfers in question.¹⁷⁵ In addition, where a policyholder's conduct has caused bodily injury or property damage, the policyholder arguably possesses, at a minimum, a conditional right under its insurance policies, and hence, even though this right may be conditioned on the subsequent imposition of liability for such conduct, the policyholder's conditional right is transferable.¹⁷⁶

V. RECENT DEVELOPMENTS

Several recent court decisions have addressed the rights of a successor to access insurance coverage for pre-transfer losses.

A. *PILKINGTON AND GLIDDEN*

The Ohio Supreme Court recently issued two decisions holding that, where a successor assumed liabilities under a contract, the rights to coverage did not automatically transfer to the successor by operation of

175. See, e.g., *Gopher Oil Co. v. American Hardware Mut. Ins. Co.*, 588 N.W.2d 756, 764 (Minn. App. 1999) (refusing to follow *Quemetco* because, while the loss at issue in *Quemetco* under California law arguably did not occur until Congress enacted CERCLA in 1980, the loss at issue in *Gopher Oil* clearly occurred under Minnesota law at the time of the contamination).

176. See *supra* Section IV.A.

law: *The Glidden Co. v. Lumbermens Mut. Cas. Co.*¹⁷⁷ and *Pilkington N. Am., Inc. v. Travelers Cas. & Sur. Co.*¹⁷⁸

In order to address whether the insurance rights could be transferred, the *Pilkington* Court first examined the corporate history, which the Court set forth as follows: prior to 1986, various insurance companies issued occurrence policies (the "LOF policies") to Libbey-Owens-Ford Glass Company ("LOF Glass Co.").¹⁷⁹ In 1986, Pilkington purchased LOF Glass Co.'s glass-manufacturing business in a two-part transaction. First, in February 1986, LOF Glass Co. placed the assets and liabilities of its glass-manufacturing division into a new wholly-owned subsidiary, LOF Glass, Inc., pursuant to a Transfer and Assumption Agreement.¹⁸⁰ Second, in March 1986, LOF Glass Co. entered into a Share Exchange Agreement with Pilkington Brothers P.L.C. and one of its subsidiaries, Pilkington Holdings, Inc., pursuant to which the Pilkington entities acquired all of the stock of the newly-formed LOF Glass, Inc.¹⁸¹ In July 2000, LOF Glass, Inc. was renamed Pilkington North America.¹⁸² As a result of the transactions, Pilkington obtained both the glass business and the environmental liabilities arising from the business, including liabilities arising from conduct by LOF Glass Co.¹⁸³ Pilkington sought coverage for defense and indemnification for those liabilities under the LOF policies.¹⁸⁴

The court was presented with the question whether, despite the presence of anti-assignment conditions in the policies, Pilkington had the right to defense and indemnification under the LOF policies for the environmental liabilities it had assumed.¹⁸⁵ The Ohio Supreme Court certified three questions of state law from the United States District Court for the Northern District of Ohio, Western Division.¹⁸⁶ The three questions

177. 861 N.E.2d 109 (Ohio 2006).

178. 681 N.E.2d 121 (Ohio 2006). The issue of a successor's rights to coverage also has been recently addressed in the courts of Indiana, and is pending before the Indiana Supreme Court in the case of *Travelers Cas. & Sur. Co. et al. v. U.S. Filter Corp.*, 870 N.E.2d 529, 541 (Ind. Ct.App. 2007) (holding that "a chose in action arises under an occurrence-based insurance policy at the time of the covered loss.... The lack of a specifically defined amount of recovery is not fatal to the determination that a chose in action exists."), *opinion vacated and transfer granted*, 878 N.E.2d 222 (Ind. Dec. 20, 2007).

179. *Pilkington*, 861 N.E.2d at 124.

180. *Id.*

181. *Id.*

182. *Id.*

183. *Id.*

184. *Id.*

185. *Id.*

186. *Id.* at 123.

addressed by the court were: (i) Whether Pilkington's demand for defense and indemnification constituted a "chose in action"; (ii) whether anti-assignment conditions in the policies barred Pilkington's acquisition of such a chose in action; and (iii) whether rights to coverage for pre-transfer occurrences automatically followed liabilities by operation of law when the liabilities had been assumed by contract.¹⁸⁷

The court, rejecting the reasoning of the *Henkel* court that a chose in action arises when a sum certain is due and payable, held that "a chose in action arises under an occurrence-based insurance policy at the time of the covered loss. The distinction created in *Henkel* does not align with the obligations recognized in Ohio that the insured's right to recover arises automatically at the time of loss."¹⁸⁸ The court further ruled in favor of the Successor Insured Position that "[w]e see no reason to deviate from the standard rule on this issue, and thus we hold that the chose in action as to the duty to indemnify is unaffected by the anti-assignment provision when the covered loss has already occurred."¹⁸⁹

Finally, the court rejected Pilkington's argument that, because it had assumed liabilities by contract, it should be able to access the insurance rights by operation of law. Rather, the court recognized that insureds may intend to transfer liabilities while retaining the insurance assets that may respond to those liabilities, and reasoned that "[t]he parties specifically contract to control liability. Allowing indemnity to follow liability as a matter of law interferes with that control."¹⁹⁰ Accordingly, the court held that "when a covered occurrence under an insurance policy occurs before liability is transferred to a successor corporation, coverage does not arise by operation of law when the liability was assumed by contract."¹⁹¹

Relying on the reasoning set forth in the *Pilkington* decision, the Ohio Supreme Court in *Glidden* reversed the pro-successor holding of the Ohio Court of Appeals that rights to coverage followed liabilities by operation of law.¹⁹² Specifically, the Ohio Court of Appeals had held that Glidden's rights to coverage arose by operation of law, following certain historical liabilities that had been transferred to it. In so holding, the Court of Appeals had rejected the reasoning in *Henkel* that permitting the transfer of

187. *Id.*

188. *Id.*

189. The court did not reach a definitive holding regarding the transferability of the insurers' duty to defend under the policies. *Id.* at 134.

190. *Id.* at 131.

191. *Id.*

192. *Glidden Co. v. Lumbermens Mut. Cas. Co.*, 861 N.E.2d 109, 115 (Ohio 2006).

insurance rights by operation of law would undercut the freedom of parties to contract as they please. Reversing the Court of Appeals, the Ohio Supreme Court reiterated the reasoning set forth in *Pilkington* and held that rights to insurance coverage do not follow the transfer of liabilities by operation of law.¹⁹³

B. ELLIOTT

In another recent Ohio decision, *Elliott Co. v. Liberty Mut. Ins. Co.*,¹⁹⁴ the district court for the Northern District of Ohio framed the question before it as follows: “[T]he specific issue in this case [is] whether coverage can pass by operation of law where liability was assumed by contract.”¹⁹⁵

Specifically, the facts in *Elliott* were described by the court as follows: In 1957, the original Elliott Company and Carrier Corporation (“Carrier”) merged and Elliott Company was dissolved and operated thereafter as a division of Carrier (“Elliott Division”).¹⁹⁶ For the next six years, the defendant insurer issued policies that insured Carrier and “The Elliott Company, A Division of Carrier Corporation.”¹⁹⁷ In 1979, United Technologies Corporation (“UTC”) acquired Carrier, and the Elliott Division continued to operate as a division of Carrier.¹⁹⁸

In 1981, UTC incorporated Elliott Turbomachinery Company, Inc. (“Elliott Turbo”), and UTC, Carrier, and Elliott Turbo entered into an “Agreement and Plan of Reorganization and Corporate Separation” (“Separation Agreement”).¹⁹⁹ Under the Separation Agreement, the parties agreed to transfer all of the assets and liabilities of the Elliott Division to Elliott Turbo.²⁰⁰ In the *Elliott* action, Elliott Turbo contends that, pursuant to the Separation Agreement, it also had transferred to it the insurance

193. *Id.* Based on the specific facts presented, the court further rejected Glidden’s arguments that rights to coverage were expressly transferred by the terms of the corporate transactional documents at issue, that the insurers were collaterally estopped from raising certain defenses to coverage, and that the insurers’ “corporate history” defense was barred by waiver and/or equitable estoppel. *Id.* at 115-116.

194. *Elliott Co. v. Liberty Mut. Ins. Co.*, 434 F. Supp. 2d 483 (N.D. Ohio 2006), *rev’d in part on reconsideration*, 239 F.R.D. 479 (N.D. Ohio Aug. 8, 2006). See *supra* note 134.

195. *Id.* at 495.

196. *Id.* at 486.

197. *Id.*

198. *Id.*

199. *Id.*

200. *Id.*

rights under the 1957-63 Carrier policies.²⁰¹ However, the exhibit to the Separation Agreement that is identified therein as listing the specific assets transferred to Elliott Turbo has been lost and, as a result, the insurer argues that Elliott Turbo cannot establish that the insurance rights were transferred to it by contract.²⁰²

When plaintiff Elliott Co. sought coverage under the Carrier policies for asbestos claims arising from the pre-transfer alleged conduct of the Elliott Division and Elliott Turbo, the insurer argued that, among other things, the anti-assignment conditions in its policies barred the assignment of coverage for such claims.²⁰³ Disagreeing with the insurer's position, the court noted that the "vast majority of courts, including courts in Ohio, Pennsylvania, Connecticut, New York and Delaware, hold that no-assignment clauses do not prevent the voluntary assignment of coverage rights under occurrence-based policies for claims related to preassignment occurrences."²⁰⁴ Following such courts and rejecting the conflicting view espoused in *Henkel*, the court concluded that "no-assignment clauses do not preclude the assignment of coverage for preassignment occurrences."²⁰⁵

Having found that the insurers' anti-assignment conditions did not apply, the court then addressed whether the parties intended in the relevant transactional agreements to transfer to plaintiff the rights to the coverage at issue. The court initially found that the parties did not intend to transfer rights under the Carrier policies to plaintiff under the 1981 Separation Agreement.²⁰⁶ In addition, the court held that the rights under the Carrier policies were not transferred to plaintiff by "operation of law" where the liabilities at issue had been transferred to plaintiff by contract.²⁰⁷ In so holding, the court stated that, "[i]f sophisticated parties to a corporate transaction do not intend for the entity acquiring liability to also succeed to coverage, there is no reason for the courts to rewrite their contracts."²⁰⁸

201. *Id.*

202. *Id.* at 491.

203. *Id.* at 486-87.

204. *Id.* at 490.

205. *Id.* at 491.

206. *Id.* at 492. The court subsequently granted Elliott's motion for reconsideration and held that whether rights to coverage under the Carrier policies were transferred under the 1981 Separation Agreement is an issue of disputed fact. *Elliott Co. v. Liberty Mutual Co.*, 239 F.R.D. 4791, 481 (N.D. Ohio Aug. 8, 2006).

207. *Elliott*, 434 F.Supp. 2d at 496 ("When a successor entity acquires liability by contract, it is not entitled to coverage for that liability unless coverage was also acquired by contract.").

208. *Id.* at 498.

C. *HOLLOWAY*

The Oregon Supreme Court adopted a different approach to the issue in *Holloway v. Republic Indem. Co. of America*.²⁰⁹ In *Holloway*, the insured sought coverage under a “Worker’s Compensation and Employers’ Liability Policy” for an injury claim brought by one of the insured’s employees.²¹⁰ After the insurer denied coverage, the insured and claimant reached a settlement that stipulated to the entry of a judgment against the insured and to a covenant not to execute on that judgment against the insured for more than a fraction of the judgment.²¹¹ Under the settlement agreement and notwithstanding an anti-assignment condition in the policy, the insured also assigned her rights against the insurer for indemnity payments or any breach of the insurance contract to the claimant.²¹² The claimant then sought to recover from the insurer on the grounds that the anti-assignment condition was ambiguous and should be construed to not apply to losses that took place prior to the assignment.²¹³

Rejecting the validity of the assignment, the Oregon Supreme Court held that the anti-assignment condition in the policy did not distinguish between pre- and post-transfer losses: “Nothing in the [anti-assignment] clause suggests a limitation to pre-loss rights or duties or provides an exception for post-loss rights or duties. Reading such an exception into the policy would not be reasonable and would ‘insert what has been omitted.’”²¹⁴ Accordingly, the Oregon Supreme Court concluded that the anti-assignment clause in the employers’ liability policy at issue was unambiguous and precluded the insured’s assignment of rights.²¹⁵

VI. CONCLUSION

After successfully defeating their coverage obligations in *Henkel*, insurers have been more aggressively raising the anti-assignment condition to attack policyholders’ claims for insurance coverage for latent bodily

209. 147 P.3d 329 (Or. 2006).

210. *Id.* at 332.

211. *Id.*

212. *Id.*

213. *Id.* at 330.

214. *Id.* at 334 (quoting OR. REV. STAT. § 42.230).

215. *Id.* at 335 (“[T]he anti-assignment clause in question is not ambiguous ... we conclude that that clause prohibited the assignment of rights from the insured to Holloway because the insured had not obtained [the insurer’s] written consent.”).

injury and property damage, such as environmental, asbestos and other delayed-manifestation claims. To counter these arguments by insurers, Successor Insureds may rely on decisional law holding that anti-assignment conditions do not preclude the transfer of insurance rights relating to bodily injury or property damage that took place prior to the transfer. These cases may successfully undermine insurers' arguments, concluding that a policyholder may transfer to a third party its liability insurance rights without its insurers' consent, whether the corporate transaction in which the insurance rights were transferred was a merger, stock sale, dissolution, or asset sale, even where the injury or damage at issue did not manifest until years after the transaction.

THE “RACE CARD” AND REFORMING AMERICAN HEALTH INSURANCE

Dayna Bowen Matthew

A person’s race defines little that is biologically distinctive. However, as a social construct,¹ race is a powerful determinant. For example, race stubbornly continues to serve as a determinant of health care status, access, outcomes and medical well-being in America. For the one-third of Americans who self-identify as racial or ethnic minorities,² their race accurately predicts that they are more likely to be uninsured³ no matter what their income level or socio-economic status is,⁴ and completely independent of the level of education they may attain.⁵ Hispanics are the most likely group of Americans to be uninsured; 33% of Latinos (“non-white Hispanics”) in this country were uninsured in 2001.⁶ African-Americans followed closely (19% uninsured) and 18% of Asians were uninsured while only 14% of white Americans lacked health insurance during the same period,⁷ although the United States Census Bureau estimates that whites represent over 66% of the American population.⁸ The simple fact is not only that more minorities than white Americans are uninsured, but that among racial and ethnic minority Americans, a substantially greater share are uninsured than are covered by health insurance.

This disproportionate representation of minorities among the uninsured means that racial minorities are less likely to visit a primary care physician than whites; more likely to receive an inferior quality of care for cancer,

1. See Ian F. Haney Lopez, *The Social Construction of Race: Some Observations on Illusion, Fabrication, and Choice*, 29 Harv. C.R.-C.L. L. Rev. 1 (1994).

2. AGENCY FOR HEALTH CARE RESEARCH & QUALITY, U.S. DEP’T OF HEALTH & HUMAN SERV., PUBL’N NO. 06-0017, 2005 NATIONAL HEALTHCARE DISPARITIES REPORT 119 (2005) [hereinafter *AHRQ DISPARITIES REPORT*], available at <http://www.ahrq.gov/qual/Nhdr05/nhdr05.pdf>.

3. See generally *id.*

4. *Id.* at 91.

5. *Id.* at 90-93.

6. U.S. CENSUS BUREAU, U.S. DEP’T OF COMMERCE, PUBL’N NO. P60-223, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2002 7 (2003), available at <http://www.census.gov/prod/2003pubs/p60-223.pdf>.

7. *Id.*

8. U.S. CENSUS BUREAU, U.S. DEP’T OF COMMERCE, STATE & COUNTRY QUICKFACTS (2008), available at <http://quickfacts.census.gov/qfd/states/00000.html>.

diabetes, heart disease and HIV/AIDS than whites; and by some measures, are more likely than whites to suffer iatrogenic injury when they do finally receive health care.⁹ The evidence shows that it does not matter whether one is a wealthy member of a minority group, or a poor one, a well-educated or marginally-educated minority, a young or elderly minority; every member of racial and ethnic minority groups in America is more likely to have no health insurance than her white counterparts notwithstanding any other demographic characteristics they might share. Changing the health care system that has resulted in these disparities is currently the policy issue of choice.

Health care reform has been a centerpiece of virtually all the presidential candidates' platforms this election year. Each major political party has articulated a general approach toward providing health insurance coverage for the 46 million uninsured in this nation. Although the details of these various plans and approaches may differ, the many proposals to reform the American health insurance system fall into broad general categories, each likely to have an objectively identifiable, and predictable impact on people who are members of racial and ethnic minorities. This essay examines and compares the likely impact of two major health insurance reform proposals on the health insurance disparities that persist for ethnic and racial minority Americans. More specifically, this essay describes the extent to which these competing approaches to health insurance reform are likely to either help exacerbate or eradicate existing health care disparities.¹⁰

9. See *AHRQ Disparities Report*, *supra* note 2.

10. My observations will depend on a few assumptions that I will state expressly at the outset. There are many determinative factors that contribute to the health care disparities that separate the health status and outcomes of minority and majority Americans, socio-economic differences, levels of stress, social and behavioral choices such as diet and exercise, these and other factors all contribute to disparate health outcomes. Some biological differences that trend along racial and ethnic lines, as well as environmental risk factors, and differences in morbidity and mortality rates that differ with ethnicity may all be responsible to some extent for disparities now well documented. However, this essay is about the confirmed link between health insurance status and health status. That is, I assume that the answer to the question of whether increased health insurance coverage will ultimately result in improved health care status is "yes." I assume that increased health insurance coverage will lead to increased access to health care, which will improve the quality of health care which will result in improving the health outcomes and status of those who are able to obtain health insurance.

MINORITY WORKERS AND EMPLOYER-BASED HEALTH INSURANCE

First and foremost it is important to understand that disparities in health care flow directly from disparate access to health insurance coverage that minorities experience through our employer-based insurance system. Employers are the source of health insurance coverage for nearly 60% of all Americans.¹¹ Thus, the structural relationship between minority Americans and their level of employment, fundamentally determines their health insurance status. For example, Latinos are far less likely to be insured simply because they are also far less likely to have jobs that provide health benefits.

The dominance of employer-based health insurance is largely an accident of this country's economic history. Employers responded to post-World War II wage freezes by offering health benefits as an alternative way to attract and retain labor.¹² Later, the federal government began to subsidize this method of compensation.¹³ Beginning in 1954, federal tax subsidies available to employers made contributions they paid on behalf of employees to purchase health insurance premiums deductible as a business expense.¹⁴ Moreover, the amount of those health insurance premiums paid for employees is also excludable from the employee's taxable income.¹⁵ The outcome is that this federal tax subsidy of employer-based insurance was estimated to be worth \$188.5 billion per year which is more than the approximately \$171.9 billion spent on Medicaid public insurance for the categorically poor and disabled in the same period.¹⁶

Poor Americans and those Americans belonging to ethnic and racial minority groups have not fared comparatively well under this employer-based health insurance model. Three sets of data explain why. First, the number of minority workers employed by smaller firms; second the

11. David S. Johnson, Chief, Housing and Household Economic Statistics, U.S. Census Bureau, Remarks at the News Conference on 2006 Income, Poverty and Health Insurance Coverage Estimates from the Current Population Survey and the American Community Survey (Aug. 28, 2007), *available at* http://www.census.gov/Press-Release/www/2007/djohnson_remarks07iph.htm.

12. David Blumenthal, *Employer-Sponsored Health Insurance in the United States – Origins and Implications*, 355 NEW ENG. J. MED. 82, 83 (2006).

13. *Id.*

14. *Id.*

15. *Id.*

16. Laura D. Hermer, *Private Health Insurance in the United States: A Proposal for a More Functional System*, 6 HOUS. J. HEALTH L. & POL'Y 1, 17 & n.117 (2005).

number of minority workers who are part-time rather than full-time employees; and third, the rate at which minority employees decline to accept partial payment of health insurance premiums offered on their behalf are datasets that all provide insight into the way that employer-based health insurance disadvantages minorities. Understanding these three factors in turn is prerequisite to understanding the effect that insurance reform proposals have on minority versus majority Americans.

Small employers provide less coverage than larger employers. Minority workers are disproportionately represented in smaller firms. Only 43% of firms employing fewer than 25 employees offer health benefits while over 81% of firms which employ 100 or more employees provide health insurance.¹⁷ However Hispanic-, Black-, and Asian-American employees comprise 25.2%, 16.6%, and 9.5% of all workers in firms with fewer than 25 employees.¹⁸ Put another way, over half the small-firm workers in America belong to these three minority groups who comprise only 30% of the general population. Moreover, as the size of American firms increases, thus increasing the likelihood that an employer can afford to provide health benefits to its employees, the number of Hispanic employees in these large firms declines.¹⁹ It is easy, therefore, to see why and how Hispanic-Americans suffer a greater incidence of un-insurance than any racial or ethnic group in the nation.

Most uninsured workers are low-income, part-time, minority workers who are most likely young, female members of racial and ethnic minority groups. In 2003, 30% of workers earning less than \$20,000 were uninsured while only 5.8% of workers earning \$50,000 or more were similarly situated.²⁰ Also, employers who do not offer health insurance are more likely to employ a higher number of part-time, rather than full-time workers, and part-time employees are more likely to be minority, female and poor.

Poorer workers have lower "take-up" rates, declining partial assistance offered to pay their insurance premiums as part of employer-sponsored programs more often than wealthier workers; these poorer workers are disproportionately members of racial and ethnic minority groups. While 19% of workers making less than the federal poverty level decline employment-based health insurance when offered, only 2% of workers fail

17. *Id.* at 17.

18. Brian Headd, *The Characteristics of Small Business Employees*, MONTHLY LABOR REV. 13, 14-15 (April 2000).

19. *Id.* at 15.

20. Hermer, *supra* note 16, at 18.

to “take-up” employment-based health insurance when offered these benefits once their incomes reach or exceed 300% of the federal poverty level.²¹ This is because employees’ premium shares represent a higher percentage of poor employees’ incomes than of wealthier employees’ incomes.

In summary, the racial and ethnic composition of America’s workforce is structurally skewed to concentrate minority workers in those jobs where health insurance is least accessible. Minority workers are more likely to be employed in part-time jobs with small employers who pay a smaller share of their health insurance premiums. The outcome is predictable: more minority employees than majority employees are uninsured.

MARKET-BASED PROPOSALS TO REFORM EMPLOYER-BASED INSURANCE

At this writing, four candidates remain in the race for the Republican nomination for president of the United States.²² All four have proposed a version of health insurance reform that they characterize as “market-based” reform and that features a role for individual health savings accounts.²³ Generally, health savings accounts (HSA’s) are tax-favored plans that allow consumers to self-insure to cover their first-dollar health expenditures, while carrying high-deductible health insurance policies to pay for catastrophic and last-dollar care. Professor Regina Jefferson has observed that these accounts benefit wealthy Americans more than they benefit middle-income or poor consumers.²⁴ Moreover, HSA’s are most advantageous for the healthy that have relatively low medical expenditures and therefore can use the HSA account as a pre-tax savings plan. Finally, individuals who are knowledgeable and able to be vigilant to control the order and timing of their medical expenses can take greater advantage of the limitations that apply to investing and deducting expenses from their

21. *Id.* at 19.

22. John McCain, Mitt Romney, Mike Huckabee, and Ron Paul.

23. See Kaiser Family Foundation & Health Policy Alternatives, *Former 2008 Presidential Candidate Health Care Proposals: Side-by-Side Summary* (2008), <http://www.health08.org/sidebyside.cfm> (click on link to view pdf); *On the Issues: Straight Talk on Health System Reform*, John McCain 2008 – John McCain for President, <http://www.johnmccain.com/Informing/Issues/> (click on “Health Care” in left hand column) (last visited Mar. 26, 2008).

24. Regina T. Jefferson, *Medical Savings Accounts: Windfalls for the Healthy, Wealthy & Wise*, 48 CATH. U. L. REV. 685, 689 (1999).

HSA's. In a pithy but accurate summary, Jefferson points out that HSA plans disproportionately benefit those in society least in need of assistance: those who are already "healthy, wealthy and wise."²⁵

The average American spends approximately \$975 annually on health care.²⁶ Individuals whose employers contribute more than this, either to their HSA accounts or to pay premiums, gain the most from these plans because they will be able to rollover the HSA funds not used to cover health expenses in a given year. These accounts favor those who are able to pay the high deductibles on policies that accompany HSA's, out of their current income. Americans who do not have the discretionary income to cover several thousand dollars of health expenses out-of-pocket, are not helped by having access to these plans. Moreover, low and moderate income taxpayers benefit significantly less than high income tax payers from HSA accounts because they tend to save less. This is confirmed by evidence from IRA savings accounts which are analogous. Only 26.5% of households earning under \$25,000 made IRA contributions while 43.8% of those earning \$200,000 to \$500,000 made these IRA contributions.²⁷ Minority households are disproportionately over-represented among these lower income households and therefore are unlikely to efficiently make use of the savings benefits offered by HSA's.²⁸ Conversely, minority households are disproportionately under-represented in higher income tax bracket households which are those most able to benefit from the tax advantages available through HSA's. The exclusion benefits under HSA plans benefit wealthy more than moderate and low income taxpayers for two additional reasons. First, the value of the exclusion increases as income rises because of the progressive tax structure that takes larger percentages of the exclusion for higher income families. Second, upper income taxpayers are likely to work for employers who pay a more generous share of their health premiums or make a more generous HSA contribution.

In summary, the feature shared by conservative health reform proposals is to place more discretion and control with the consumer. HSA accounts

25. *Id.*

26. Blue Cross and Blue Shield, *Healthcare Financing Trends*, 2008 MED. COST REFERENCE GUIDE 10.

27. P. Sailer, V. Bryant & S. Holden, *Trends in 401(k) and IRA Contribution Activity*, 1999-2002 at 168-169, available at <http://www.irs.gov/pub/irs-soi/05sailer.pdf>. (last visited Nov. 13, 2008).

28. William H. First, *Overcoming Disparities in U. S. Health Care*, 24 HEALTH AFF. 445, 446 (2005).

are a key part of this approach to health insurance reform. Yet, the impact of this market-based reform is likely to be less helpful to minorities than it will be to white Americans directly, and will be highly unlikely to have any meaningful impact on reducing health care disparities between minority and majority Americans.

EXPANDING PUBLIC INSURANCE ALTERNATIVES TO EMPLOYER-BASED INSURANCE

Two Democratic candidates for president remain in the 2008 election.²⁹ Both purport to advocate “universal health coverage” as their approach to reforming our current system of health care financing. Both feature the Democrats’ standard approach to covering the uninsured: expansion of current public insurance programs including Medicaid and the State Children’s Health Insurance Program.³⁰ This reform bypasses the vicissitudes of disparities associated with the employer-based insurance system discussed above. However, increasing minority Americans’ reliance on public insurance programs exposes these beneficiaries to the most politically volatile and vulnerable sources of health insurance available. Medicaid has never been politically popular as evinced by the annual efforts to cut back benefits and reduce expenditures to the disabled and “categorically needed” covered by these plans. Yet, minority Americans rely on public health insurance programs more than white Americans. In 2006, 24.35% of all American Indian and Alaskan Native Americans obtained Medicaid coverage; 26.8% of African Americans and 23.1% of Hispanic Americans were covered by Medicaid in the same year. However, in 2006 only 9.5% of all Non-Hispanic Whites received Medicaid benefits.³¹ Twenty eight percent of African-Americans, 23% of

29. Barack Obama and Hillary Clinton.

30. See Edward M. Kennedy, *The Role of the Federal Government in Eliminating Health Disparities*, 24 HEALTH AFF. 452, 454 (2005) (stating that Senator Kennedy is the ranking Democrat on the Health, Education, Labor and Pensions Committee and that in his view “[t]he most effective way to benefit minorities is through the expansion of Medicaid and the State Children’s Health Insurance Program...”); Kaiser Family Foundation & Health Policy Alternatives, *2008 Presidential Candidate Health Care Proposals: Side-by-Side Summary* (2008), <http://www.health08.org/sidebyside.cfm> (click on check boxes below Clinton and Obama and then click “compare”).

31. National Center for Health Statistics, Health, United States, 2007 With Chartbook on Trends in the Health of Americans at 402, Table 138 (2007) (Yet, this relatively small proportion of the Non-Hispanic White population accounts for over 43% of all Medicaid enrollees. See, Department of Health and Human Services, *A Profile of Medicaid*

Latino-Americans, 10% of Asian-Americans and 12% of White-Americans rely upon Medicaid, Medicare, or other forms of publicly sponsored health insurance.³²

Ironically, although a greater share of minority groups rely upon public health insurance than white Americans, minorities in America are curiously *under*-represented in the most universal of all universal health insurance plans. Medicare covers all Americans who reach age 65, regardless of race, ethnicity, income, health status, or any other demographic. Nevertheless, by comparing the race of Medicare beneficiaries to their prorated representation in the general population, we can confirm that race matters even in universal health plans. For example, whites comprise 82% of elderly Medicare beneficiaries, but represent just over 65% of the American population.³³ Conversely, 7% of Medicare beneficiaries are Latino and 8% are African-American while these minority groups represent 14% and 12% of the general population respectively.³⁴ A partial explanation for this disparity must include the fact that minority Americans do not live as long as white Americans do and therefore are a smaller percentage of the elderly population covered by Medicare. However, it is also important to recognize that even universal public health insurance coverage cannot, alone, erase health disparities between minority and majority Americans, and may, if not carefully structured, actually exacerbate racial health disparities.

WHAT WILL WORK?

Some reforms in private health insurance can reduce disparities. For example, to the extent that health insurance reform addresses economic disadvantages faced by employees seeking to purchase health insurance through their employers, either by subsidizing those premium contributions or by limiting the premiums that can be charged to a percentage of income, minorities will be more likely to choose private health coverage for themselves and their families. Further, those health insurance reform plans that include relief for small businesses facing catastrophic health expenses,

Chartbook 2000 at 24 (HCFA Form 2082) available at <http://www.cms.hhs.gov/TheChartSeries/downloads/2Tchartbk.pdf>.

32. KAISER FAMILY FOUNDATION, KEY FACTS: RACE, ETHNICITY & MEDICAL CARE 14 (2007), available at <http://www.kff.org/minorityhealth/upload/6069-02.pdf>.

33. Department of Health and Human Services, *Medicare: A Profile* at 70 (July 2000) available at <http://www.cms.hhs.gov/TheChartSeries/downloads/35chartbk.pdf>.

34. *Id.*

either through reimbursements or tax credits, are more likely to reduce the number of minorities who are uninsured. But perhaps the most meaningful of all possible health insurance reforms is one that neither conservatives nor liberals have yet addressed.

Health insurers are uniquely positioned to collect race and ethnicity data to evaluate demographically information such as the incidence and size of claims, usage of covered services, patterns of provider practices, availability of coverage plans, incidence of certain covered diseases and catastrophes, and a host of other indicators that would shed light on the facts about the access racial and ethnic minority Americans have to health insurance and care. This data is largely unavailable from any other source. Yet, the 2004 report of the American Health Insurance Plans found that nearly half of health plan enrollees belong to plans that do not collect data on race and ethnicity.³⁵ Here, the wisdom of the adage that is true for engineers and physicists is also true for health insurance reform: “that which can be measured can be changed.” Current proposals to reform health insurance track political platforms and priorities and they accurately reflect the broad principles of their sponsors. However, in order to purposefully address the racial disparities in health care access that are attributable to minorities’ status within the financing structure of the American health care system, reformers absolutely must not be afraid to “play the race card.”

35. AMERICA’S HEALTH INSURANCE PLANS (AHIP), HEALTH INSURANCE PLANS ADDRESS DISPARITIES IN CARE: HIGHLIGHTS OF A 2004 AHIP/RWJF QUANTITATIVE SURVEY - COLLECTION AND USE OF DATA ON RACE AND ETHNICITY 1 (2004), *available at* <http://www.ahip.org/content/default.aspx?bc=38|82|5859>. The Robert Wood Johnson Foundation and the U.S. Department of Health and Human Services’ Agency for Healthcare Research and Quality have formed the National Health Plan Collaborative to reduce racial and ethnic disparities and improve the overall quality of healthcare in the United States. This Collaborative has sponsored efforts to improve collection of race and ethnicity data. NATIONAL HEALTH PLAN COLLABORATIVE, PHASE ONE SUMMARY REPORT 1-2, 7 (2006), *available at* <http://www.rwjf.org/files/publications/other/NHPCSummaryReport2006Revised.pdf>.

THE PRACTICAL RAMIFICATIONS OF DUAL SOVEREIGNTY IN PROSECUTING DECLARATORY JUDGMENT ACTIONS AGAINST STATE AND FEDERAL GOVERNMENTS

Daniel Maldonado
Steven Plitt

I. INTRODUCTION

The declaratory judgment action is the modern legal vehicle for determining whether coverage exists under an insurance policy. Generally, declaratory judgments were not recognized as remedies in the United States until the early 1900's.¹ In 1922, the Commissioners on Uniform State Laws adopted the Uniform Declaratory Judgment Act (UDJA),² effectively standardizing declaratory judgments throughout the United States.³ The great majority of states have adopted some version of the UDJA.⁴

1. Russell B. Hill, *Should Anticipation Kill Application of the Declaratory Judgment Act?*, 26 T. JEFFERSON L. REV. 239, 240 (2004); Mark Peter Henriques, *Desuetude and Declaratory Judgment: A New Challenge to Obsolete Laws*, 76 VA. L. REV. 1057, 1060-61 (1990).

2. UNIF. DECLARATORY JUDGMENTS ACT § 1 to 17 (2007).

3. See Hill, *supra* note 1, at 240; Sean Gay, *Declaratory Relief and Sovereign Immunity in Oregon: Can Someone Tell Me if I Turned Square Corners?*, 40 WILLAMETTE L. REV. 563, 567 (2004); See also Willy E. Rice, *Insurance Contracts and Judicial Discord Over Whether Liability Insurers Must Defend Insureds' Allegedly Intentional and Immoral Conduct: A Historical and Empirical Review of Federal and State Courts' Declaratory Judgments—1900-1997*, 47 AM. U. L. REV. 1131, 1142 (1998).

4. See ALA. CODE §§ 6-6-220 to -232 (2007); ARIZ. REV. STAT. ANN. §§ 12-1831 to -1846 (2007); ARK. CODE ANN. §§ 16-111-101 to -111 (2007); COLO. REV. STAT. §§ 13-51-101 to -115 (2007); DEL. CODE ANN. tit. 10, §§ 6501 to -13 (2007); FLA. STAT. §§ 86.011 to -111 (2007); GA. CODE ANN. §§ 9-4-1 to -10 (2007); IDAHO CODE §§ 10-1201 to -1217 (2007); 735 ILL. COMP. STAT. 5/2-701 (2007); IND. CODE ANN. § 34-14-1-1 to -16 (2007); IOWA R. CIV. P. 1.1101 to -1109 (2007); KAN. STAT. ANN. §§ 60-1701 to -1716 (2007); LA. CODE CIV. PROC. ANN. arts. 1871 to -83 (2007); ME. REV. STAT. ANN. tit. 14, §§ 5951 to -63 (West 2007); MD. CODE ANN., CTS. & JUD. PROC. §§ 3-401 to -415 (West 2007); MASS. GEN. LAWS ch. 231A, §§ 1-9 (2007); MINN. STAT. §§ 555.01 to -16 (2007); MO. REV. STAT. §§ 527.010 to -130 (2007); MONT. CODE ANN. §§ 27-8-101 to -313 (2007); NEB. REV. STAT. §§ 25-21, 149 to -164 (2007); N.J. STAT. ANN. §§ 2A:16-50 to -62 (West 2007); N.M. STAT. ANN. §§ 44-6-1 to -15 (2007); N.C. GEN. STAT. §§ 1-253 to -267 (2007); N.D. CENT. CODE § 32-23-01 to -13 (2007); OHIO REV. CODE ANN. §§ 2721.01 to -16 (West 2007); OKLA. STAT. tit. 12, §§ 1651 to -57 (2007); OR. REV. STAT. §§ 28.010 to -160 (2007); 42 PA. CONS. STAT. §§ 7531 to -41

Following the states' lead, in 1934 Congress enacted the Federal Declaratory Judgment Act⁵ (FDJA), and authorized federal courts to similarly grant declaratory judgment relief.⁶ As early as 1937, the United States Supreme Court held that an insurance coverage dispute presents a judicial controversy for which a District Court has the authority to hear and determine pursuant to the FDJA.⁷

Declaratory judgment actions provide "a speedy and inexpensive method of adjudicating legal disputes without invoking coercive remedies ..."⁸ Declaratory judgments may often be employed to dispose of issues in the initial stages of a dispute before the parties would otherwise need to

(2007); R.I. GEN. LAWS §§ 9-30-1 to -16 (2007); S.C. CODE ANN. §§ 15-53-10 to -140 (2007); S.D. CODIFIED LAWS §§ 21-24-1 to -16 (2007); TENN. CODE ANN. §§ 29-14-101 to -113 (2007); TEX. CIV. PRAC. & REM. CODE ANN. §§ 37.001 to -11 (Vernon 2007); UTAH CODE ANN. § 78-33-1 to -13 (2007); VT. STAT. ANN. tit. 12, §§ 4711 to -25 (2007); VA. CODE ANN. §§ 8.01-184 to -191 (2007); WASH. REV. CODE ANN. §§ 7.24.010 to -144 (2007); W. VA. CODE, §§ 55-13-1 to -16 (2007); WIS. STAT. § 806.04 (2007); WYO. STAT. ANN. §§ 1-37-101 to -115 (2007).

5. 28 U.S.C. § 2201(a) (2000).

6. Rice, *supra* note 3, at 1143-44 (The FDJA provides in relevant part: "In a case of actual controversy within its jurisdiction ... any court of the United States, upon the filing of an appropriate pleading, may declare the rights and other legal relations of any interested party seeking declaration, whether or not further relief is or could be sought. Any such declaration shall have the force and effect of a final judgment or decree and shall be reviewable as such."); See 28 U.S.C. § 2201(a) (2000).

7. See *Aetna Life Ins. Co. v. Haworth*, 300 U.S. 227, 244 (1937); See also *Am. Nat'l Fire Ins. Co. v. The Hungerford*, 53 F.3d 1012, 1015-16 (9th Cir. 1995) ("We have previously held that a dispute between an insurer and its insured over the duties to defend and indemnify satisfies the requirement for purposes of the [Federal] Declaratory Judgment Act, whether or not there is an underlying state court action."). The FDJA does not provide an independent basis for federal jurisdiction and a district court must rely upon its original jurisdiction to entertain a declaratory judgment action. See *Skelly Oil Co. v. Phillips Petroleum Co.*, 339 U.S. 667, 671 (1950) (noting that federal jurisdiction can be based upon diversity and the district court has discretion to exercise that jurisdiction); *Wilton v. Seven Falls Co.*, 515 U.S. 277, 282 (1995) ("Brillhart makes clear that District Courts possess discretion in determining whether and when to entertain an action under the [Federal] Declaratory Judgment Act.").

8. See *Sherwood Med. Indus., Inc. v. Deknatel, Inc.*, 512 F.2d 724, 729 (8th Cir. 1975); *Beacon Const. Co., Inc. v. Matco Elec. Co., Inc.*, 521 F.2d 392, 397 (2d Cir. 1975); See also Ryan R. Dreyer, *Civil Procedure-Discouraging Declaratory Actions In Minnesota-The Res Judicata Effect Of Declaratory Judgments in Light of State v. Joseph*, 29 WM. MITCHELL L. REV. 613, 616 (2002); Eugene L. Stewart, *Procedural Issues and Remedies in the Administration and Judicial Resolution of Customs and International Trade Cases: The Role of Sanctions, Contempt, Assessment of Costs, and Extraordinary Legal Remedies in Reforming Practice Before The Court of International Trade*, 3 FLA. INT'L L. J. 341, 391 (1988).

proceed to full blown litigation.⁹ Thus, declaratory judgments often serve to eliminate unnecessary time and expense otherwise incurred in fishing expeditions in many contexts.¹⁰

In crafting the declaratory judgment complaint, as counsel begins to pencil in the captioned names, a question arises as to who needs to be named as defendants in the suit. Obviously, in the insurance context, the insureds must be named since their policies are being interpreted.¹¹ Whether necessary or not,¹² insurance companies also typically name the underlying claimants as defendants because they are considered to have an interest in the outcome of a declaratory judgment action that will determine insurance coverage for their claims and insurers wish to ensure that the determination is binding on all parties. However, unique problems can arise based upon this practice. One such problem, which is the focus of this article, arises where both the state and federal governments are the underlying tort claimants.

It is not uncommon for the actions of an insured to implicate both state and federal regulations, especially in the area of environmental

9. Dreyer, *supra* note 8, at 616.

10. *Id.*

11. See *State Farm Mut. Auto. Ins. Co. v. Huges*, 32 F.Supp. 665, 669 (E.D.S.C. 1940); *Lumbermens Mut. Cas. Co. of Ill. v. Cieri*, 23 F.Supp. 435, 435-36 (M.D.Pa. 1938); *Auto Mut. Indem. Co. v. Dupont*, 21 F.Supp. 606, 608 (D.Del. 1937); *Cont'l Mut. Ins. Co. v. Cochrane*, 4 P.2d 308, 310 (Colo. 1931); See also *Weissbard v. Potter Drug & Chem. Corp.*, 69 A.2d 559, 561 (N.J.Super.Ch. 1949) ("A contract may not be declared null and void in the absence of a party to the contract.").

12. There is some debate among jurisdictions on whether a third-party claimant is a necessary and/or indispensable party in a declaratory judgment action filed by an insurance carrier against its insured for purposes of determining the insurance carrier's liability for an incident between the insured and the third-party. Compare *CFI Wis., Inc. v. Hartford Fire Ins. Co.*, 230 F.R.D. 552, 554 (W.D. Wis. 2005) ("[An] injured third-party is a necessary party in a declaratory judgment action by an insurance company seeking to determine its liability arising from an occurrence between its insured and the injured party."), and *Am. Standard Ins. Co. of Wis. v. Rogers*, 123 F.Supp. 2d 461, 467 (S.D. Ind. 2000); *Evangelical Lutheran Church in Am. v. Atl. Mut. Ins. Co.*, 173 F.R.D. 507, 508-09 (N.D. Ill. 1997), with *Liberty Mut. Ins. Co. v. Treesdale, Inc.*, 419 F.3d 216, 230 (3d Cir. 2005) and *Ace Am. Ins. Co. v. Paradise Divers, Inc.* 216 F.R.D. 537, 540 (S.D.Fla. 2003) (holding that because the third-party claimant's interests are adequately represented by the insured in a declaratory judgment action regarding coverage under the insured's policy, the third-party claimant is not indispensable), and *Austin Fireworks, Inc. v. T.H.E. Ins. Co.*, 809 F.Supp. 829, 830-31 (D.Kan. 1992), and *Black Diamond Girl Scout Council, Inc. v. St. Paul Fire & Marine Ins. Co.*, 621 F.Supp. 96, 97-98 (S.D.W.Va. 1985), and *County of Wyoming, NY v. Erie Lackawanna Ry. Co.*, 360 F.Supp. 1212, 1215 (W.D.N.Y. 1973).

regulation.¹³ For example, an insured performs clearing operations to prepare a piece of land for development. However, the insured contractor, during the course of these clearing operations, discharged dredged or fill material into neighboring waterways. Based upon these actions, both the federal and state governments asserted separate claims against the insured pursuant to the federal Clean Water Act ("CWA")¹⁴ and the state clean water laws¹⁵ respectively. The action brought by the federal government was filed in federal court and the action brought by the state government was filed in state court. Based upon certain terms of the policy, it is the insurance company's belief that the insured contractor is not covered under the policy for the allegations in either lawsuit. Both lawsuits arise out of precisely the same actions committed by the insured. It does not make judicial or economic sense to litigate the same coverage issue in two separate declaratory judgment proceedings which could result in inconsistent adjudications.¹⁶ Accordingly, the insurer wishes to file a

13. *See, e.g.* *Lumbermens Mut. Cas. Co. v. Belleville Indus., Inc.*, 938 F.2d 1423, 1424 (1st Cir. 1991) (involving lawsuits filed against insured company by both the United States and the Commonwealth of Massachusetts under the Comprehensive Environmental Response, Compensation and Liability Act [CERCLA] and other environmental and civil statutes seeking damages and cleanup costs resulting from pollution of the Acushnet River and New Bedford Harbor); *Kelley v. Thomas Solvent Co.*, 790 F.Supp. 731, 733 (W.D. Mich. 1991) (involving claims by both the United States and the State of Michigan under section 107 of CERCLA, 42 U.S.C. § 9607, for the recovery of response costs incurred in connection with the contamination of the Verona Well Field); *Maryland Cas. Co. v. Wausau Chem. Corp.*, 809 F.Supp. 680, 689-90 (W.D. Wis. 1992) (involving a declaratory judgment action brought by an insurer against an insured chemical company seeking declaration that there was no obligation to defend or indemnify the insured chemical company for CERCLA response costs incurred pursuant to consent decree with the United States and the State of Wisconsin); *Hybud Equip. Corp. v. Sphere Drake Ins. Co., Ltd.*, 597 N.E.2d 1096, 1097 (Ohio 1992) (involving a declaratory judgment action over right to defense and indemnity from insurers for lawsuits filed by the United States Environmental Protection Agency and the State of Ohio due to leakage of pollutants from landfill). *See also* *Certain Underwriters at Lloyd's v. Health Care Mgmt. Partners, Ltd.*, 2006 WL 2050962, *3-*4 (D. Colo. 2006) (involving a declaratory judgment action over coverage for claims alleged against an insured by both the United States and the State of Colorado for false or fraudulent claim submissions under Medicare and Medicaid).

14. 33 U.S.C. §§ 1251-1387 (2007).

15. *See, e.g.*, MASS. GEN. LAWS ch. 21, §§ 26-53 (2007); MO. REV. STAT. §§ 204.006-.141 (2007); N.C. GEN. STAT. §§ 143-211 (2007); WASH. REV. CODE ANN. §§ 90.48.010-.910 (2007).

16. Courts have consistently recognized that inconsistent adjudications do not serve the interests of justice and judicial economy. *See Hendrix v. Raybestos-Manhattan, Inc.*, 776 F.2d 1492, 1495 (11th Cir. 1985) (holding that one of the factors to consider in

single declaratory judgment lawsuit against the insured, the federal government, and the state government in order to resolve this single issue of coverage and have a single binding decision on all of the interested parties.

It is at this point that the insurance company faces a conundrum: where should the insurer file this action, state or federal court? Can the insurer file such a single action against both governmental entities in either state or federal court? Does the insurer have to file two separate actions? If so, will an insurer be faced with the possibility of two divergent and inconsistent decisions on the same issue? These are just some of the issues that an insurer must grapple with when a contemplated declaratory judgment involves dual sovereigns—the state and federal governments.

In order to be able to determine the best path through this maze of problems, it is important to first examine the history and development of the underlying principles. The first part of this article discusses the concept of dual sovereignty of federal and state governments as was designed in the Constitution and preserved through judicial and legislative actions. Part II analyzes the actions of the federal courts in preserving dual sovereignty through use of the abstention doctrine. Part III addresses the enactment of the Eleventh Amendment and the impact of this Constitutional amendment on dual sovereignty through the delineation of sovereign immunity reserved by the States. The second part of this article addresses the specific dilemma created by dual sovereignty principles, as set forth briefly above, where an insurance company wishes to file a declaratory judgment action against both the state and federal governments. Each possible scenario is addressed separately: (1) Part IV discusses the issues involved in filing a declaratory judgment against the federal government in federal court; (2) Part V discusses the issues involved in filing a declaratory judgment against the federal government in state court; (3) Part VI discusses the issues involved in filing a declaratory judgment against the state government in federal court; and (4) Part VII discusses the issues involved in filing a declaratory judgment against the state government in state court.

consolidation of cases under Rule 42(a) of the Federal Rules of Civil Procedure is the risk of inconsistent adjudications of common factual and legal issues); FED. R. CIV. P. 23(b)

(b) Class Actions Maintainable. An action may be maintained as a class action if the prerequisites of subdivision (a) are satisfied, and in addition: (1) the prosecution of separate actions by or against individual members of the class would create a risk of (A) inconsistent or varying adjudications with respect to individual members of the class which would establish incompatible standards of conduct for the party opposing the class, . . .

Mitchell-Tracey v. United Gen. Title Ins. Co., 237 F.R.D. 551, 559 (D.Md. 2006).

Finally, in part VIII, the article addresses how to effectively try and rectify the procedural obstacle course created by dual sovereignty and reach a practical solution for this procedural conundrum.

II. PRESERVATION OF DUAL SOVEREIGNTY THROUGH FEDERAL ABSTENTION.

Dual sovereignty is the foundation of the governmental structure of the United States.¹⁷ Under the concept of dual sovereignty, states hold sovereignty¹⁸ concurrently with the federal government. This shared sovereignty is subject only to those limitations imposed by the supremacy clause of the United States Constitution.¹⁹

Federal courts recognize dual sovereignty through the Federal Abstention Doctrine. There are many types of abstention.²⁰ The principle variants of abstention are: Pullman,²¹ Burford,²² and Younger²³ abstention. The various types of abstention “are not rigid pigeon holes into which federal courts must try to fit cases. Rather, they reflect a complex of

17. Gregory v. Ashcroft, 501 U.S. 452, 457 (1991).

18. For the advantages and disadvantages of the dual sovereignty system: see generally Michael W. McConnell, *Federalism: Evaluating the Founders' Design*, 54 U. CHI. L. REV. 1484, 1491-1511 (1987); Deborah J. Merritt, *The Guarantee Clause and State Autonomy: Federalism for a Third Century*, 88 COLUM. L. REV. 1, 3-10 (1988).

19. Tafflin v. Levitt, 493 U.S. 455, 458 (1990) (stating that the central purpose of the sovereign immunity doctrine is to accord the States the respect owed to them as “joint sovereigns”); Puerto Rico Aqueduct & Sewer Auth. v. Metcalf & Eddy, Inc., 506 U.S. 139, 146 (1993).

20. Many concepts can be labeled as part of the abstention doctrine. A case in point is exemplified by the so-called *Rooker-Feldman* abstention which originated from *Rooker v. Fidelity Trust Co.*, 263 U.S. 413 (1923) and *Dist. of Columbia Court of Appeals v. Feldman*, 460 U.S. 462 (1983) (stating that under *Rooker-Feldman* abstention, the court recognizes that Congress has conferred original jurisdiction and not appellate jurisdiction on the federal district courts.) *Rooker-Feldman* abstention prevents a state court party from having two bites at the apple: one through the state courts with a petition to the U.S. Supreme Court and the other through a subsequent collateral attack originating in the federal courts. Where a party begins litigating a constitutional matter in state court and stops short of petitioning the U.S. Supreme Court, and then initiates litigation in federal court regarding the same constitutional matter, the federal district court can abstain. *Rooker-Feldman* abstention essentially holds that the federal district court does not have appellate jurisdiction over the state court. The state court party should continue through the state court proceeding up through the U.S. Supreme Court. *Id.*

21. See *R.R. Comm’n of Tex. v. Pullman Co.*, 312 U.S. 496 (1941).

22. See *Burford v. Sun Oil Co.*, 319 U.S. 315 (1943).

23. See *Younger v. Harris*, 401 U.S. 37 (1971).

considerations designed to soften the tensions inherent in a system that contemplates parallel judicial processes.”²⁴

Federal courts have original power to abstain from exercising jurisdiction through principles of equity.²⁵ In order to maintain a balance between state and federal sovereignty, the abstention doctrine was judicially formulated.²⁶ Cases merit abstention where the proceedings implicate some discernable state interest or state law.²⁷ While the state interest test has been substantially mitigated recently,²⁸ there must at least be a superficial state interest present to trigger abstention.

Under the Pullman abstention, “when a federal constitutional claim is premised on an unsettled question of state law, the federal court should stay its hand in order to provide the state court’s an opportunity to settle the underlying state-law question and thus avoid the possibility of unnecessarily deciding a constitutional question.”²⁹ Under Burford

24. *Pennzoil Co. v. Texaco, Inc.*, 481 U.S. 1, 11 n.9 (1987).

25. *See Quackenbush v. Allstate Ins. Co.*, 517 U.S. 706, 717 (1996) (“It has long been established that a federal court has the authority to decline to exercise its jurisdiction when it ‘is asked to employ its historic powers as a court of equity.’” (quoting *Fair Assessment in Real Estate Assn., Inc. v. McNary*, 454 U.S. 100, 120 (1981) (Brennan, J., concurring))).

26. *See generally* Charles Alan Wright, et al., *FEDERAL PRACTICE AND PROCEDURE*, § 4241 (1988). (stating that supporters of abstention assert that it promotes a wiser balance of judicial federalism); *see, e.g.*, Randall P. Bezanson, *Abstention, the Supreme Court and Allocation of Judicial Power*, 27 *VAND. L. REV.* 1107, 1151 (1974); David L. Shapiro, *Jurisdiction and Discretion*, 60 *N.Y.U. L. REV.* 543 (1985) (writing that critics assert the superiority of federal courts over state courts as enforcers of federal rights); Burt Neuborne, *The Myth of Parity*, 90 *HARV. L. REV.* 1105, 1131 (1977) (“The only judicial forums in our system capable of enforcing counter majoritarian checks in a sustained, effective manner are the federal courts.”).

27. *See Huffman v. Pursue, Ltd.*, 420 U.S. 592 (1975).

28. Ann Althouse, *The Misguided Search for State Interest in Abstention Cases: Observations on the Occasion of Pennzoil v. Texaco*, 63 *N.Y.U. L. REV.* 1051, 1083-90 (1988) (arguing that *Pennzoil* eliminates the state interest test as a requirement for abstention).

29. *See R.R. Comm’n of Tex. v. Pullman Co.*, 312 U.S. 496 (1941). *Orr v. Orr*, 440 U.S. 268, 285 (1979) (Powell, L., dissenting) (quoting *Harris County Comm’rs Court v. Moore*, 420 U.S. 77, 83 (1975)). *See also Moore*, 442 U.S. at 427-28 (“A federal action should be stayed pending determination in state court of state-law issues central to the constitutional dispute.”); *Elkins v. Moreno*, 435 U.S. 647 (1978); *Ohio Bureau of Employment Serv. V. Hoodry*, 431 U.S. 471, 477 (1988) (“[*Pullman* abstention] involves an inquiry focused on the possibility that the state courts may interpret a challenged state statute so as to eliminate or at least to alter materially, the constitutional question presented.”); *Boehning v. Indiana State Emp. Assn., Inc.*, 423 U.S. 6 (1975); *Askew v. Hargrave*, 401 U.S. 476 (1971); *Reetz v. Bozanich*, 397 U.S. 82 (1970); *Aldrich v. Aldrich*, 378 U.S. 540 (1964); *Dresner v. Tallahassee*, 378 U.S. 539 (1964); *Clay v. Sun Ins. Office*,

abstention,³⁰ the Federal Court considers the independence of state governments in carrying out domestic policy, and seeks to avoid conflict between state and federal courts.³¹ *Burford* abstention is not based on a need to defer to a concurrent state court proceeding. Rather, *Burford* counsels that a district court should abstain from hearing a case if the case involves a difficult question of state law or if it implicates a state regulatory scheme, regardless of the presence of an ongoing state proceeding.³² Under *Younger* abstention³³, “a federal court should not enjoin a state criminal prosecution begun prior to the institution of the federal suit except in very

Ltd., 363 U.S. 207 (1960); *Meridian v. Southern Bell Tel. & Tel. Co.*, 358 U.S. 639 (1959); *Spector Motor Service, Inc. v. McLaughlin*, 323 U.S. 101 (1944).

30. See *Burford v. Sun Oil Co.*, 319 U.S. 315 (1943) (stating that the origin of *Burford* Abstention is equitable in nature. *Quackenbush*, 517 U.S. at 728 (stating that lower federal courts have disagreed on the propriety of abstention in cases involving legal rather than equitable claims). Compare *Tribute Co. v. Abiloe*, 66 F.3d 12, 16 (2nd Cir. 1995) (“*Burford* Abstention is generally appropriate in cases where equitable relief is sought.”); *Garamendi v. Allstate Ins. Co.*, 47 F.3d 350, 356 (9th Cir. 1995) (“A District Court may not abstain under *Burford* when the plaintiff seeks only legal relief.”); *Riley v. Simmons*, 45 F.3d 764, 777 (3rd Cir. 1995) (Nigard, J., concurring) (“*Burford* Abstention is simply not available when legal, rather than equitable or declaratory, relief is sought.”); *Fragoso v. Lopez*, 991 F.2d 878, 882 (1st Cir. 1993) (holding that abstention is improper in cases asserting only inequitable claims); *University of Maryland v. Peat Marwick Main & Co.*, 923 F.2d 265, 271 (3rd Cir. 1991) (*Burford* Abstention is limited to federal courts sitting in equity); with *Riley*, 45 F.3d at 772, n.7, (expressing doubt that the restriction against applying *Burford* Abstention in non-equitable suits is still good law); *Gen. I Glass Indus. v. Monsour Medical Found.*, 973 F.2d 197, 202 (3rd Cir. 1992) (“Decisional authority remains inconclusive as to whether *Burford* Abstention may be ordered only in cases of inequitable nature. . . .”); *Taffet v. Southern Co.* 930 F.2d 847, 853 n.4 (11th Cir. 1991) (“Though abstention rulings premised upon principles of comity and federalism were originally developed in the context of actions seeking equitable relief, those principles have also been applied to actions seeking monetary actions.”); *Lac D’Amiante du Quebec, Ltee v. Am.Home Assurance Co.*, 864 F.2d 1033, 1044 (3rd Cir. 1988) (“If the relief sought is legal and the disruption is of the extent and character suggesting that *Burford* Abstention is appropriate, a refusal to abstain simply because the federal court is not sitting as a court of equity makes no sense.”).

31. *Quackenbush*, 517 U.S. at 727-28. *Burford* Abstention requires a district court to abstain from hearing a case if the case involves a different question of state law or if it implicates a state regulatory scheme, regardless of the presence of an ongoing state proceeding. *New Orleans Public Serv., Inc. v. Council of New Orleans*, 491 U.S. 350, 361 (1989). As such, it is not predicated upon a need to defer to a concurrent state court proceeding.

32. *New Orleans Public Serv., Inc.*, 491 U.S. at 361.

33. See *Younger*, 401 U.S. 37. *Samuels v. Mackell*, 401 U.S. 66, 68 (1971). See also *Colorado River Water Conservation Dist. v. United States*, 424 U.S. 800, 816 (1976) (“[A]bstention is inappropriate where, absent bad faith, harassment, or a patently invalid state statute, federal jurisdiction has been invoked for the purpose of restraining state criminal proceedings.”).

unusual situations, where necessary to prevent immediate irreparable injury.”³⁴ Although the Younger doctrine has equitable origins, the Supreme Court has, in large part, abandoned the equitable foundation in cases subsequent to Younger.³⁵

The court appears to be moving towards a merger of the various abstention doctrines.³⁶ For example, in *Colorado River Water Conservation District v. United States*,³⁷ the court tied the variations on abstention together under the broader category of “exceptional circumstances.”³⁸ The Court found that there are “exceptional circumstances” relating to “[w]ise judicial administration, giving regard to conservation of judicial resources and comprehensive disposition of litigation,”³⁹ and that the exceptional circumstances should be weighed against the duty to exercise federal jurisdiction.⁴⁰ The Pullman, Burford

34. Samuels, 401 U.S. at 69. See also *Colorado River*, 424 U.S. at 816 (“Abstention is inappropriate where, absent bad faith, harassment, or a patently invalid state statute, federal jurisdiction has been invoked for the purpose of restraining state criminal proceedings.”).

35. See George D. Brown, *When Federalism and Separation of Powers Collide--Rethinking the Younger Abstention* 59 GEO. WASH. L. REV. 114, 120 n.56 (1990) (writing that post-*Younger* cases have strayed from the equitable rationale); Rehnquist, *supra* note 36, at 1088 n. 219, 1089; Howard B. Stravitz, *Younger Abstention Reaches a Civil Maturity: Pennzoil Co., v. Texaco Inc.*, 57 FORDHAM L. REV. 997, 1007 (1989) (writing that *Younger*'s progeny toppled the equitable pillar in favor of federalism and comity); Larry W. Yackle, *Explaining Habeas Corpus*, 60 N.Y.U. L. REV. 991, 1042 (1985) (arguing that the Supreme Court has eroded the equitable foundation to the doctrine). Numerous lower court cases have addressed *Younger* as a case based on comity and federalism as opposed to equity. See, e.g. *Warmust v. Melahn*, 62 F.3d 252, 255 (8th Cir. 1995) *vacated* 116 S. Ct. 2493 (1996) (stating that Younger Abstention has its roots in comity and federalism); *Schilling v. White*, 58 F.3d 1081, 1084 n.3 (6th Cir. 1995) (stating that the *Younger* doctrine is founded in federalism and comity); *Gwyned Properties v. Lower Gwyned Township*, 970 F.2d 1195, 1199-2000 (3rd Cir. 1992) (same).

36. See Georgene M. Vairo, *Making Younger Civil: The Consequences of Federal Court Deference to State Court Proceedings*, 58 FORDHAM L. REV. 173, 212 (1989) (stating that similarities between various abstention doctrines outweigh differences and therefore one test for abstention should be adopted); and Stephen Jon Moss, *Comment, Pennzoil: A Merger of Federal Abstention*, 13 OKLA. CITY U. L. REV. 607 (1988) (stating that *Pennzoil* effectively merged *Pullman* and *Younger* abstention doctrines).

37. 424 U.S. 800 (1976).

38. *Id.* at 813-17.

39. *Id.* at 817 (quoting *Kerotest Mfg. Co. v. C-O-Two Fire Equip. Co.*, 342 U.S. 180, 183 (1952)).

40. *Id.* at 817-19. A plurality of the court in *Will v. Calvert Fire Ins. Co.*, 437 U.S. 655, 665-67 (1978), contradicted the *Colorado River* “exceptional circumstances” doctrine. Writing for the plurality, Justice Rehnquist observed that the district court had discretion to accept concurrent jurisdiction of a state court matter. *Id.* at 664. Justice Rehnquist found

and Younger abstention doctrines are not the only three general categories of “exceptional circumstances.”⁴¹ If the facts of a case fall outside those three general categories, there are other principles which can give rise to application of abstention.⁴²

that “it is well established that the pendency of an action in the state court is no bar to proceedings concerning the same matter in the federal court having jurisdiction.” *Id.* Justice Rehnquist stated: “[I]t is equally well settled that a district court is ‘under no compulsion to exercise that jurisdiction’,... where the controversy may be settled more expeditiously in the state court.” *Id.* at 662-63. He emphasized that the “right to proceed with a duplicative action in a federal court can never be said to be ‘clear and undisputable’.” *Id.* at 666 n.8. Five Justices joined the plurality in *Calvert* establishing the principle that *any* likelihood of duplicative litigation was sufficient to justify abstention.” *Id.* at 663-64. This plurality contradicted the exception.

The conflicting holdings of *Colorado River* and *Calvert* were clarified in *Moses Cone Mem’l Hosp. v. Mercury Constr. Corp.*, 460 U.S. 1 (1983). The Court in *Moses* held that the “exceptional circumstances” test of *Colorado River* should be used by district courts in determining to stay an action in favor of state court proceedings. *Id.* at 13-19. The *Moses* court formulated two additional factors for the “exceptional circumstances” test: (1) the determination of which forum’s substantive law would govern the merits of the litigation; and (2) the adequacy of the state forum to protect the parties’ rights. *Id.* at 23-27. The *Moses* court reaffirmed the doctrine that federal courts have a “[virtual] unflagging obligation” to exercise the jurisdiction given to them. *Id.* at 15. After *Moses* the circuit courts were divided over which standard governed a district court’s decision to stay or dismiss a declaratory judgment action where there were parallel state proceedings. The Third, Fourth, Fifth and Ninth circuits applied the discretionary standard articulated in *Brillhart v. Excess Ins. Co. of America*, 316 U.S. 491 (1942) and *Calvert*. See, e.g., *Terra Nova Ins. Co. v. 900 Bar, Inc.*, 887 F.2d 1213 (3rd Cir. 1989); *Mitcheson v. Harris*, 995 F.2d 235, 237-38 (4th Cir. 1992) (the “exceptional circumstances” test of *Colorado River* and *Moses* is inapplicable in declaratory judgment actions); *Travelers Ins. Co. v. Louisiana Farm Bureau Fed’n Inc.*, 996 F.2d 774, 778 n.12 (5th Cir. 1993) (same); *Cont’l Cas. Co. v. Robsac Indus.*, 947 F.2d 1367 (9th Cir. 1991); *Chamberlin v. Allstate Ins. Co.*, 931 F.2d 1361, 1366 (9th Cir. 1991) (*Colorado River* test does not apply to declaratory relief actions because they have “special status”).

However, other circuit courts applied the narrow exceptional circumstances test developed in *Colorado River* and expanded in *Moses*. See, e.g., *Employers Ins. of Wassau v. Missouri Elec. Works*, 23 F.3d 1372, 1374 n.3 (8th Cir. 1994) (Following *Colorado River* and *Moses* the district court was not justified in staying or dismissing a declaratory relief action absent “exceptional circumstances.”); *Lumberman’s Mut. Cas. Co. v. Connecticut Bank & Trust Co.*, 806 F.2d 411, 413 (2nd Cir. 1986) (same). A middle ground between these two positions can be found. See, e.g., *Fuller Co. v. Ramon I. Gill, Inc.*, 782 F.2d 306, 308-11 (1st Cir. 1986) (stating that where the state court has expended significant resources through the adjudicatory process of the state law claims, federal courts may decline to exercise jurisdiction over a declaratory judgment action).

41. *Colorado River*, 424 U.S. at 814-17.

42. *Id.* at 817 (“Although this case falls within none of the abstention categories, there are principles unrelated to considerations of proper constitutional adjudication and regard

A separate line of abstention cases has developed defining the boundaries of discretion in the context of federal declaratory judgment actions ("FDJA").⁴³ Jurisdiction under the FDJA is discretionary and not compulsory.⁴⁴ The Act itself states that the district court "may declare the rights and other legal relations of any interested party."⁴⁵ A separate variation of abstention has arisen in the context of the FDJA when a parallel case is pending in state court at the same time the federal district court is being asked to exercise its discretion to accept jurisdiction under the FDJA.⁴⁶ The doctrine enunciated by the court in *Brillhart v. Excess Insurance Company of America*⁴⁷ directs the court regarding its exercise of discretion to deny jurisdiction.

In *Brillhart*, the insurance company brought suit for declaratory relief in federal court to determine its obligation in a pending state court proceeding.⁴⁸ The *Brillhart* court found that it would "ordinarily be uneconomical as well as vexatious for a federal court to proceed in a declaratory judgment suit where another suit is pending in a state court presenting the same issues, not governed by federal law, between the same parties."⁴⁹ The *Brillhart* court indicated that district courts should assess whether the controversy could better be resolved in the state court proceeding in determining whether to abstain.⁵⁰ This assessment may require "inquiry into the scope of the pending state court proceeding and the nature of defenses open there."⁵¹ Further, "[t]he federal court may have

for federal-state relations which govern in situations involving the contemporaneous exercise of concurrent jurisdictions, either by federal courts or by state and federal courts.").

43. In *Quackenbush v. Allstate Insur. Co.*, 517 U.S. 706, 718 (1996), the Supreme Court found that the various forms of the abstention doctrine had been extended to "certain classes of declaratory judgments, the granting of which is generally committed to the court's discretion" (citation omitted). It is interesting to note that in *Great Lakes Dredge & Dock Co. v. Huffman*, 319 U.S. 293, 297 (1943) and *Samuels v. Mackell*, 401 U.S. 66, 69-70 (1971) the Supreme Court recognized that the actions were brought pursuant to the FDJA but did not apply the discretion under this statute but rather applied different forms of the abstention doctrine. For a thorough discussion of the effects of *Quackenbush* on diversity jurisdiction in general see Lewis Yelin, Note, *Burford Abstention in Actions for Damages*, 99 COLUM. L. REV. 1871 (1999).

44. See *Wilton v. Seven Falls Co.*, 515 U.S. 277, 286-87; *Gov't Employees Ins. Co. v. Dizon*, 133 F.3d 1220, 1223 (9th Cir. 1998).

45. 28 U.S.C. § 2201 (2000) (emphasis added).

46. *Maryland Casualty Co. v. Knight*, 96 F.3d 1284, 1288 (9th Cir. 1996).

47. 316 U.S. 491, 495 (1942).

48. *Id.* at 492-94.

49. *Id.* at 495.

50. *Id.*

51. *Id.*

to consider whether the claims of all parties in interest can satisfactorily be adjudicated in that proceeding, whether necessary parties have been joined, whether such parties are amenable to process in that proceeding, etc.”⁵²

In *Wilton v. Seven Falls Company*,⁵³ the Supreme Court established the Brillhart test and not the Colorado River exceptional circumstances” test as governing a district court’s exercise of discretion in a federal declaratory judgment action, brought during the pendency of parallel state court proceedings.⁵⁴ “Congress, and not the judiciary, defines the scope of federal jurisdiction within the constitutionally permissible bounds.”⁵⁵ This concept is foundational upon the idea that an exercise of judicial discretion to abstain constitutes a judicial usurpation of legislative power.⁵⁶ To function properly, American constitutional democracy requires courts to act within their congressionally-conferred jurisdictional province.⁵⁷

52. *Id.*

53. 515 U.S. 277 (1995).

54. *Id.* at 289-90.

55. *New Orleans Pub. Serv., Inc. v. Council of New Orleans*, 491 U.S. 350, 359 (1989) (citing *Kline v. Burke Constr. Co.*, 260 U.S. 226, 234 (1922)).

56. Martin H. Redish, *Abstention, Separation of Powers, and the Limits of the Judicial Function*, 94 YALE L.J. 71, 79 (1984). Some commentators have argued for the expansion of federal judicial power for two principle reasons: (1) fear of perceived local prejudices, and (2) fear that a local forum will ignore or disregard federal law. David J. McCarthy, Note, *Preclusion Concerns as an Additional Factor When Staying a Federal Suit in Deference to a Concurrent State Proceeding*, 53 FORDHAM L. REV. 1183, 1198 (1985). See also Paul M. Bator, *The State Courts and Federal Constitutional Litigation*, 22 WM & MARY L. REV. 605, 607 (1981) (noting that federal courts are the preferred forum for determination and analysis of constitutional principles); David A. Sonenshin, *Abstention: The Crooked Course of Colorado River*, 59 TUL. L. REV. 651 (1985) (noting that because federal judges have life tenure, they are less subject to the vagaries and pressures of local public opinion, Congress has preserved the federal forum to litigants).

57. In *Tenn. Valley Auth. v. Hill*, 437 U.S. 153 (1978) the court observed:

Our system of government is, after all, a tripartite one, with each branch having certain defined functions delegated to it by the constitution. While “[i]t is emphatically the province and duty of the judicial department to say what the law is,” ... it is equally – and emphatically – the exclusive province of the Congress not only to formulate legislative policies and mandate programs and projects, but also to establish their relative priority for the Nation. Once Congress, exercising its delegated powers, has decided the order of priorities in a given area, it is for the Executive to administer the laws and for the courts to enforce them when enforcement is sought.

Id. at 194 (quoting *Marbury v. Madison*, 5 U.S. 137, 177(1803)). See also *California v. Sierra Club*, 451 U.S. 287, 298 (1981); *Touche Ross & Co. v. Redington*, 442 U.S. 560, 576 (1979).

Although the Federal Abstention Doctrine has an essential role to play in judicial preservation of dual sovereignty within the judiciary, it has been criticized on constitutional grounds.

A well established tradition of the common law is that a court must exercise the jurisdiction that it possesses.⁵⁸ Chief Justice Marshall declared that judicial conduct contrary to this principle would be in direct defiance of the prerogatives set forth in the Constitution. Marshall opined, “[we] have no more right to decline the exercise of jurisdiction which is given, than to usurp that which is not given. The one or the other would be treason to the constitution.”⁵⁹ “Congress, and not the Judiciary, defines the

58. *Ohio v. Wyandotte Chems. Corp.*, 401 U.S. 493, 496-97 (1971) (citing *Cohens v. Virginia*, 19 U.S. 264, 404 (1821)). *See also* *Chicot County v. Sherwood*, 148 U.S. 529, 534 (1893) (“[T]he courts of the United States are bound to proceed to judgment and to afford redress to suitors before them in every case to which their jurisdiction extends. They cannot abdicate their authority or duty in any case in favor of another jurisdiction.”) (citations omitted); *Willcox v. Consol. Gas Co.*, 212 U.S. 19, 40 (1909) (“[W]hen a federal court is properly appealed to in a case over which it has by law jurisdiction, it is its duty to take such jurisdiction The right of a party plaintiff to choose a Federal court where there is a choice cannot be properly denied.”) (citations omitted). *McClellan v. Carland*, 217 U.S. 268, 282 (1910) (concluding that federal courts have no authority to abdicate jurisdiction because of a pending state proceeding).

59. *Cohens*, 19 U.S. at 404 (emphasis added). Chief Justice Marshall, writing for the Court, observed:

It is most true that this Court will not take jurisdiction if it should not: but it is equally true, that it must take jurisdiction if it should. The judiciary cannot, as the legislature may, avoid a measure because it approaches the confines of the constitution. We cannot pass it by because it is doubtful. With whatever doubts, with whatever difficulties, a case may be attended, we must decide it, if it be brought before us. We have no more right to decline the exercise of jurisdiction which is given, than to usurp that which is not given. The one or the other would be treason to the constitution. Questions may occur which we would gladly avoid; but we cannot avoid them. All we can do is, to exercise our best judgment, and conscientiously to perform our duty.

Id. Justice Marshall’s comments have found resonance with the court. *See, e.g.*, Justice Brennan’s warning in *Moses H. Cone Memorial Hospital v. Mercury Constr. Co.*, 460 U.S. 1, 15 (1983), where he stated that the Federal Courts have a “virtually unflagging obligation . . . to exercise the jurisdiction given them.” This belief has been expressed through leading scholarly publications. *See, e.g.*, Redish, *supra* note 56 at 112 (“[V]esting of power in the Federal Courts to adjudicate the relevant claims without a corresponding duty to do so is unacceptable.”) *See generally* Shapiro, *supra* note 26; Michael M. Wilson, Comment, *Federal Court Stays and Dismissals in Deference to Parallel State Court Proceedings: The Impact of Colorado River*, 44 UNIV. CHI. L. REV. 641, 641-42 (1977) (observing that the right to a federal forum is secured by the Constitution); Note, *Power to Stay Federal Proceedings Pending Termination of Concurrent State Litigation*, 59 YALE

scope of federal jurisdiction within the constitutionally permissible bounds.”⁶⁰

Commentators have opined that abstention can be anathema to the doctrine of separation of powers where federal jurisdictional requirements have been legally met.⁶¹

III. PRESERVATION OF DUAL SOVEREIGNTY THROUGH THE ELEVENTH AMENDMENT.

The Eleventh Amendment was enacted to delineate the scope of sovereign immunity reserved by the States.⁶² The Eleventh Amendment guarantees that non-consenting states may not be sued by private individuals in federal court.⁶³ Thus, states are immune from suits brought in federal court by their own citizens, and the citizens of other states.⁶⁴

L.J. 978, 980 (1950); Note, *Stays of Federal Proceedings in Deference to Concurrently Pending State Court Suits*, 60 COLUM. L. REV. 684, 687 (1960) (stating that the right to a federal forum is secured by the Constitution and supportive judicial precedent). Barry Friedman, *A Revisionist Theory of Abstention*, 88 MICH. L. REV. 530 (1989); Linda S. Mullenix, *A Branch Too Far, Pruning the Abstention Doctrine*, 75 GEO. L.J. 99 (1986).

60. *New Orleans Pub. Serv., Inc.*, 491 U.S. at 359 (1989) (citing *Kline v. Burke Constr. Co.*, 260 U.S. 226, 234 (1922)).

61. See, e.g., Redish, *supra* note 56, at 77-79. Some commentators have argued for the expansion of federal judicial power for two principle reasons: (1) fear of perceived local prejudices, and (2) fear that a local forum will ignore or disregard federal law. David J. McCarthy, Note, *Preclusion Concerns as an Additional Factor When Staying a Federal Suit in Deference to a Concurrent State Proceeding*, 53 FORDHAM L. REV. 1183, 1199 n.66 (1985). See also Paul M. Bator, *The State Courts and Federal Constitutional Litigation*, 22 WM. & MARY L. REV. 605, 607 (1981) (noting that federal courts are the preferred forum for determination and analysis of constitutional principles); David A. Sonenshin, *Abstention: The Crooked Course of Colorado River*, 59 TUL. L. REV. 651 (1985) (noting that because federal judges have life tenure, they are less subject to the vagaries and pressures of local public opinion, Congress has preserved the federal forum to litigants).

62. See *Id.* at 722-23. The full breadth of the sovereign immunity retained by the States was not explicitly memorialized by Congress when the United States Constitution was ratified. In ratifying the Eleventh Amendment, Congress chose only to address the specific historical concerns when, in 1793, the United States Supreme Court erroneously held that Article III of the Constitution authorized citizens of one State to sue another State in Federal Court. *Id.* As a result, the Court has concluded that the Eleventh Amendment is only one particular exemplification of the States' sovereign immunity. *Blatchford v. Native Village of Noatak*, 501 U.S. 775, 779 (1991) (“[W]e have understood the Eleventh Amendment to stand not so much for what it says, but for the presupposition of our constitutional structure which it confirms.”).

63. E.g., *Bd. of Trs. of the Univ. of Ala. v. Garrett*, 531 U.S. 356, 363 (2001). See also, *Alden v. Maine*, 527 U.S. at 706 (1999) (applying the Eleventh Amendment to

Prior to the ratification of the United States constitution, States had inherent sovereignty and partial sovereignty was reserved under the Tenth Amendment.⁶⁵ In contrast, the doctrine of inherent sovereignty does not apply to the federal government.⁶⁶ The federal government is a sovereign

lawsuits by private individuals in state courts based upon federal causes of action); *Blatchford*, 501 U.S. 775 (applying the Eleventh Amendment to lawsuits by Indian tribes); *Monaco v. Mississippi*, 292 U.S. 313 (1934) (applying the Eleventh Amendment to lawsuits by foreign nations); *In re New York*, 256 U.S. 490 (1921) (applying the Eleventh Amendment to admiralty proceedings); *Smith v. Reeves*, 178 U.S. 436 (1900) (applying the Eleventh Amendment to lawsuits by federal corporations); *Hans v. Louisiana*, 134 U.S. 1 (1890) (applying the Eleventh Amendment to lawsuits by citizens of the State under federal-question jurisdiction).

The Eleventh Amendment, however, does not bar a suit against a State in that State's own court system nor does it bar a suit against a state in a different State court. *See, e.g.*, *Nevada v. Hall*, 440 U.S. 410 (1979). As discussed further in this Article, Congress can abrogate the state's immunity pursuant to a valid exercise of power, hence allowing a state to be sued in federal court. *See, e.g.*, *Fitzpatrick v. Bitzer*, 427 U.S. 445 (1976). There are other situations where a State can be sued in federal court. *See, e.g.*, *United States v. Mississippi*, 380 U.S. 128 (1965) (holding that a State can be sued in federal court by the United States); *South Dakota v. North Carolina*, 192 U.S. 286 (1904) (holding that a State can be sued in federal court by another State); *Ex parte Young*, 209 U.S. 123 (1908) (holding that a State can be sued in federal court by a plaintiff seeking injunctive relief in a suit against a state official).

Some commentators believe that the Eleventh Amendment is more akin to a jurisdictional bar for lack of federal subject matter jurisdiction than to true immunity. *See, e.g.*, J. Nowak, R. Rotunda & J. Young, *CONSTITUTIONAL LAW* 52 (1983); Akil Reed Amar, *Of Sovereignty and Federalism*, 96 *YALE L.J.* 1425, 1473-84 (1987). *See also*, *Edelman v. Jordan*, 415 U.S. 651, 678 (1974) ("[An] Eleventh Amendment defense sufficiently partakes of a jurisdictional bar that it need not be raised in the trial court"); *Welch v. State Dep't of Highways & Public Transp.*, 483 U.S. 468, 476 n.6 (1987) ("Eleventh Amendment immunity partakes of the nature of a jurisdictional bar") (citation omitted).

64. *Edelman*, 415 U.S. at 662-63. *See also* *Garrett*, 531 U.S. at 363; *Kimel v. Fla. Bd. of Regents*, 528 U.S. 62, 72-73 (2000); *Hans*, 134 U.S. at 15 (1890).

65. The Tenth Amendment provides: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States Respectively, or to the people." U.S. CONST. amend. X. The Supreme Court has previously delineated the limits of a State's sovereign as it relates to a dual sovereignty system:

Where state antagonism to another State or Nation begins, the state sovereignty ends, and that is at just the point where the matters of exclusive regulation within the state boundaries, the things done by or in the State, tend to pass over into the other limited sovereignties, and then the exclusive power, the reserved power, falls, or rather stops.

Kansas v. Colorado, 206 U.S. 46, 68 (1907).

66. *Perry v. United States*, 294 U.S. 330, 335 (1935) (citing *Kansas*, 206 U.S. 46).

of delegated, limited, and enumerated powers.⁶⁷ As a separate sovereign, States also inherently have sovereign immunity.⁶⁸ Sovereign immunity, as embodied by the Eleventh Amendment, serves to avoid the indignity of subjecting a State to the coercive process of judicial tribunals at the request of private parties.⁶⁹

Under the Articles of Confederation, Congress could not directly legislate the American people, but could do so only with the approval of the States.⁷⁰ The Constitutional Convention was convened, in part, because of the inadequacy of the federal government to directly legislate.⁷¹

Throughout the Constitution's ratification process States retained their sovereign immunity.⁷² The Constitutional Convention sought to restructure Congress and give it the power to legislate without the need of the state legislatures.⁷³ During the Constitutional Convention, delegates debated the merits of the Virginia and New Jersey Plans under which the federal

67. *United States v. Harris*, 106 U.S. 629, 635 (1883). "The powers of Congress are not given by the people of a single State; they are given by the people of the United States to a Government whose laws, made in pursuance of the Constitution, are declared to be supreme. Consequently, the people of a single State cannot confer a sovereignty which will extend over them." *Kansas*, 206 U.S. at 69-70.

68. *College Savings Bank v. Florida Prepaid Postsecondary Education Expense Bd.*, 527 U.S. 666, 686 n.4 (1999); *Hess v. Port Auth. Trans-Hudson Corp.*, 513 U.S. 30, 57 (1994) ("Sovereign immunity, after all, inheres in the permissible exercise of state power."); *Hans*, 134 U.S. at 13 (1890) ("It is inherent in the nature of sovereignty not to be amenable to the suit of an individual without its consent.") (quoting *THE FEDERALIST* NO. 81 (Alexander Hamilton)).

69. *Puerto Rico Aqueduct & Sewer Auth. v. Mefcalf & Eddy*, 506 U.S. 139, 146 (1993) ([The Eleventh Amendment is a] "fundamental constitutional protection . . . rooted in a recognition that the States, although a union, maintain certain attributes of sovereignty, including sovereign immunity. It thus accords the States the respect owed them as members of the federation") (citation omitted).

70. *New York v. U.S.*, 505 U.S. 144, 163 (1992) ("Congress 'could not directly tax or legislate upon individuals; it had no explicit 'legislative' or 'governmental' power to make binding 'law' enforceable as such.'") (citing Amar, *supra* note 63 at 1447).

71. *Id.*

72. *Alden v. Maine*, 527 U.S. 706, 755 (1999).

73. This issue was addressed by Alexander Hamilton:

The new National Government must carry its agency to the persons of the citizens. It must stand in need of no intermediate legislations The government of the Union, like that of each State, must be able to address itself immediately to the hopes and fears of individuals. . . .

See Hamilton, *supra* note 68, at 116.

government could exercise its powers.⁷⁴ Under the Virginia Plan, Congress could exercise legislative authority directly without employing the States as intermediaries.⁷⁵ The New Jersey Plan mirrored the status quo and Congress would continue to require the approval of the States before legislating.⁷⁶

The New Jersey Plan was objected to because it might require Congress to coerce the States into implementing legislation.⁷⁷ Consequently, the Convention adopted the Virginia Plan which provided for a constitution in which Congress would exercise its legislative authority directly over individuals, rather than over States.⁷⁸ One reason for adopting the Virginia Plan was to avoid coercing States as separate sovereign entities. Instead, Congress would be able to legally coerce individuals.⁷⁹ In providing for a stronger federal government, the framers explicitly chose a constitutional framework that conferred upon Congress the power to

74. Various proposals for the structure of the new federal government were discussed during the Constitutional Convention. However, two plans were dominant: the Virginia Plan and the New Jersey Plan. *New York*, 505 U.S. at 164.

75. Delegate Edmund Randolph first introduced the Virginia Plan. Under the Virginia Plan, Congress would exercise legislative authority directly without employing the States as intermediaries. *Id.* (citing THE RECORDS OF THE FEDERAL CONVENTION OF 1787, 21 (Max Farrand ed. 1911), hereinafter "RECORDS").

76. Delegate William Paterson first introduced the New Jersey Plan. Under the New Jersey Plan, Congress would continue to require the approval of the States before legislating like it did under the Articles of Confederation. *New York*, 505 U.S. 144, 164 (1992). (citing 1 RECORDS, *supra* note 75, at 243-44). Although both the Virginia and New Jersey plans underwent various revisions during the Convention, they remained the two primary options discussed by the delegates. *Id.*

77. *Id.* ("The true question is whether we shall adhere to the federal plan [i.e., the New Jersey Plan], or introduce the national plan. The insufficiency of the former has been fully displayed. . . . There are but two modes by which the end of a Gen[eral] Gov[ernment] can be attained: the 1st is by coercion as proposed by Mr. P[aterson's] plan[, the 2nd] by real legislation as prop[osed] by the other plan. Coercion [is] impracticable, expensive, cruel to individuals. . . . We must resort therefore to a national Legislation over individuals.")

(quoting Edmund Randolph in 1 RECORDS, *supra* note 75, at 255-56)); *see also id.* "The practicability of making laws, with coercive sanctions, for the States as political bodies, had been exploded on all hands." (quoting James Madison in 2 RECORDS, *supra* note 75, at 9)).

78. *Id.* at 165 (noting the Constitutional Convention rejected the New Jersey Plan in favor of the Virginia Plan) (citing 1 RECORDS, *supra* note 75, at 313).

79. *Id.* at 165 ("This Constitution does not attempt to coerce sovereign bodies, states, in their political capacity. . . . But this legal coercion singles out the . . . individual.") (quoting Oliver Ellsworth in 2 J. Elliot, DEBATES ON THE FEDERAL CONSTITUTION 197 (2d ed. 1863))).

regulate individuals, not States.⁸⁰ The Constitution gives Congress the authority to enact legislation requiring or prohibiting certain acts; however, Congress lacks the power directly to compel the States to require or prohibit those acts.⁸¹

Congress' authority to abrogate Eleventh Amendment immunity is limited. Because the "abrogation of sovereign immunity upsets the fundamental constitutional balance between the federal government and the states,"⁸² any judicial determination of whether abrogation has lawfully occurred are made with great care. In order to lawfully abrogate state sovereign immunity, Congress must (1) act "pursuant to a valid exercise of power"; and (2) "unequivocally express its intent to abrogate the immunity."⁸³ The power to abrogate Eleventh Amendment immunity resides in Congress' enforcement powers under Section 5 of the Fourteenth Amendment.⁸⁴ When Congress is operating under its Article 1 powers, Congress has no authority to nullify State's Eleventh Amendment immunity.⁸⁵ Under Section 5, Congress is authorized to enact remedial legislation focused on preventing violations of the Fourteenth Amendment.⁸⁶ A valid exercise of this power requires Congress to "identify conduct transgressing the Fourteenth Amendment's substantive

80. *Id.*

81. *Id.* at 166 (citing *Fed. Energy Regulatory Comm'n v. Mississippi*, 456 U.S. 742, 762-66 (1983), *Hodel v. Va. Surface Mining & Reclamation Ass'n, Inc.*, 452 U.S. 264, 288-89 (1981), and *Lane County v. Oregon*, 74 U.S. 71, 76 (1868)). *See also id.* (noting that the Commerce Clause is a constitutional provision that authorizes Congress to regulate interstate commerce directly; but does not authorize Congress to regulate state governments' regulation of interstate commerce).

82. *Dellmuth v. Muth*, 491 U.S. 223, 227 (1989) (citation omitted). *See Pennhurst State Sch. & Hosp. v. Halderman*, 465 U.S. 89, 99 (1984) ("Our reluctance to infer that a State's immunity from suit in the courts has been negated stems from recognition of the vital role of the doctrine of sovereign immunity in our federal system.").

83. *Seminole Tribe of Fla. v. Florida*, 517 U.S. 44, 55 (1996).

84. *Bd. of Trs. Of the Univ. of Ala. v. Garrett*, 531 U.S. 356, 363 (2001).

85. *Id.* at 365. Section 5 of the Fourteenth Amendment grants Congress the power to enforce the substantive guarantees contained in Section 1 by enacting "appropriate legislation"; *City of Boerne v. Flores*, 521 U.S. 507, 536 (1997). *But see Seminole*, 517 U.S. at 59 (holding that Congress only has two constitutional sources to abrogate a State's sovereign immunity; Section 5 of the Fourteenth Amendment and the Commerce Clause) (citing *Fitzpatrick v. Bitzer*, 427 U.S. 445 (1976) *Pennsylvania v. Union Gas Co.*, 491 U.S. 1 (1989))). *See also Nelson v. Miller*, 170 F.3d 641, 647-48 (6th Cir. 1999) (noting that Congress passed the ADA pursuant to its power to enforce the 14th Amendment and its power to regulate commerce).

86. *See Kimel v. Fla. Bd. of Regents*, 528 U.S. 62, 75 (2000).

provisions, and must tailor its legislative scheme to remedying or preventing such conduct.”⁸⁷

Congress has no authority to enact substantive legislation which defines the scope of the Fourteenth Amendment restrictions on the States.⁸⁸ “It is the responsibility of [t]he court, not Congress, to define the substance of congressional guarantees.”⁸⁹ In *City of Boerne v. Flores*⁹⁰ the high court formulated the “congruence and proportionality” test to determine whether the exercise of Congress’ enforcement power was remedial and appropriate or definitional and not appropriate. “There must be a congruence and proportionality between the injury to be prevented or remedied and the means adopted to that end.”⁹¹

Courts must recognize or establish two facts through reliable fact-finding to prove congruence. First, to justify the federal intervention in their affairs, the court must establish whether the state or local government has done something unconstitutional or likely unconstitutional.⁹² Second, the means chosen must be “responsive to, or designed to prevent, unconstitutional behavior.”⁹³ These determinations are made by examining the legislative record to identify the reasons for Congress’ action.⁹⁴

Eleventh Amendment immunity may be waived.⁹⁵ Generally, by participating in a federal spending program, States can waive their Eleventh Amendment immunity.⁹⁶ Congress may offer federal funding with

87. *Fla. Prepaid Postsecondary Educ. Expense Bd. v. Coll. Sav. Bank*, 527 U.S. 627, 639 (1999).

88. *Garrett*, 531 U.S. at 364; *City of Boerne*, 521 U.S. at 519.

89. *Garrett*, 531 U.S. at 365.

90. *City of Boerne*, 521 U.S. at 520.

91. *City of Boerne v. Flores*, 521 U.S. 507, 520 (1997) (“The appropriateness of remedial measures must be considered in light of the evil presented. Strong measures appropriate to address one harm may be an unwarranted response to another lesser one.”); *Bd. of Trs. Of the Univ. of Ala. v. Garrett*, 531 U.S. 356, 365 (2001).

92. *City of Boerne*, 521 U.S. at 508 (citing *The Civil Rights Cases*, 109 U.S. 3, 13 (1883)).

93. *City of Boerne*, 521 U.S. at 509.

94. *Kimel v. Fla. Bd. of Regents*, 528 U.S. 62, 88 (2000).

95. There are three exceptions to Eleventh Amendment immunity. First, Congress has the power to abrogate Eleventh Amendment immunity without the state’s consent when acting pursuant to its enforcement powers under section 5 of the Fourteenth Amendment. *Garrett*, 531 U.S. at 365; *Atascadero State Hosp. v. Scanlon*, 473 U.S. 234, 238 (1985). Second, individual suits that seek prospective relief for ongoing violations of federal law may be brought against state officials pursuant to the doctrine of *Ex parte Young*, 209 U.S. 123, 155-56 (1908). *Garrett*, 531 U.S. at 374 n.9. Third, states may voluntarily waive their Eleventh Amendment immunity. *Atascadero*, 473 U.S. at 238 n.1.

96. *Id.*

conditions attached as part of its Spending Clause powers.⁹⁷ Congress may require states to waive their sovereign immunity as a condition for receiving federal funds.⁹⁸ If Congress intends to impose this condition, the relevant statute must “manifest[] a clear intent to condition participation in the programs ... on a State’s consent to waive its constitutional immunity.”⁹⁹

The Supreme Court’s decision in *College Savings Bank v. Florida Prepaid Postsecondary Education Expense Board*¹⁰⁰ reaffirmed and strengthened the test to be applied in determining whether a state has waived its sovereign immunity. The Court emphasized that a state’s “decision to waive ... immunity [must be] ‘altogether voluntary.’”¹⁰¹ Courts may not find “implied” or “constructive” waiver of Eleventh Amendment immunity.¹⁰² “A state will be seen to have waived its Eleventh

97. *Jim C. v. United States*, 235 F.3d 1079, 1081 (8th Cir. 2000) (en banc). The Constitution empowers Congress “to lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defen[s]e and general Welfare of the United States.” U.S. CONST. art. I, § 8, cl. 1. “Incident to this power, Congress may attach conditions on the receipt of federal funds.” *Jim C.*, 235 F.3d at 1081 (quoting *South Dakota v. Dole*, 483 U.S. 203, 206 (1987)). Congress has employed this power “to further broad policy objectives by conditioning receipt of federal mon[ies] upon compliance by the recipient with federal statutory and administrative directives.” *Fullilove v. Klutznick*, 448 U.S. 448, 474 (1980) (Burger, C.J.). See also *Lau v. Nichols*, 414 U.S. 563, 569 (1974) (“power to fix terms”); *Ivanhoe Irrigation Dist. v. McCracken*, 357 U.S. 275, 295 (1958) (“impose reasonable conditions”).

98. *Jim C.*, 235 F.3d at 1081. Congress’s spending power is not unlimited. *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 n.13 (1981). In *South Dakota v. Dole*, the Court reviewed the case law concerning the spending power of Congress, noting four general restrictions. 483 U.S. at 207. First, “the exercise of the spending power must be in pursuit of ‘the general welfare.’” *Id.* See U.S. Const. art. I, §8, cl. 1. See also *Helvering v. Davis*, 301 U.S. 619, 640 (1937). Second, “if Congress desires to condition the state’s receipt of federal funds, it ‘must do so unambiguously ... enabl[ing] the states to exercise their choice knowingly, cognizant of the consequences of their participation.’” *Dole*, 483 U.S. at 207 (quoting *Pennhurst*, 451 U.S. at 17). Third, it has been “suggested (without significant elaboration) that conditions on federal grants might be illegitimate if they are unrelated ‘to the federal interest in particular national projects or programs.’” *Dole*, 483 U.S. at 207. (quoting *Massachusetts v. United States*, 435 U.S. 444, 461 (1978) (plurality opinion)). Fourth, “other constitutional provisions may provide an independent bar to [a] conditional grant of federal funds.” *Dole*, 483 U.S. at 207. (citing *Lawrence County v. Lead-Deadwood Sch. Dist.*, 469 U.S. 256, 269-70 (1985)).

99. *Atascadero*, 473 U.S. at 247.

100. *Fla. Prepaid Postsecondary Educ. Expense Bd. V. Coll. Sav. Bank*, 527 U.S. 666, 675-76 (1999).

101. *Id.* (quoting *Beers v. Arkansas*, 20 How. 527, 529 (1858)).

102. *Id.* at 680. The Court recognized, in reaching this decision, that it was overruling its decision in *Parden v. Terminal Railway of Alabama Docks Department*, 377 U.S. 184

Amendment immunity only ‘if the State voluntarily invokes [the federal court’s] jurisdiction, or else if the State makes a “clear declaration” that it intends to submit itself to’ the federal court’s jurisdiction.”¹⁰³ In *College*

(1964) “We think that the constructive-waiver experiment of *Parden* was ill conceived, and see no merit in attempting to salvage any remnant of it . . . [w]hatever may remain of our decision in *Parden* is expressly overruled.” *Coll. Sav. Bank*, 527 U.S. at 680. *Parden*-style constructive waivers that were held unconstitutional are viewed as being “fundamental[ly] different[t]” from situations where states voluntarily waived their immunity in exchange for federal funds. *Id.* at 680-81. In a different section of the *College Savings Bank* opinion, Justice Scalia reiterates that “conditions attached to a State’s receipt of federal funds are simply not analogous to *Parden*-style conditions attached to a State’s decision to engage in otherwise lawful commercial activity.” *Id.* at 678-79 n.2. The Court distinguished *Parden* from *Atascadero* which involved section 504 of the Rehabilitation Act. *Id.* In the Court’s view, *Atascadero* “suggest[ed] that a waiver may be found in a State’s acceptance of a federal grant.” *Id.* (quoting *Atascadero*, 473 U.S. at 234). The Court in *College Savings Bank* appears to have reaffirmed this observation of *Atascadero* “mak[ing] the same suggestion today, while utterly rejecting *Parden*.” *Id.*

103. *Pugliese v. Dep’t of Health and Human Serv.*, 147 F. Supp. 2d 985, 990 (D. Ariz. 2001) (quoting *Coll. Sav. Bank*, 527 U.S. at 675-76.) Following the *College Savings Bank* decision, several federal decisions have rejected the waiver concept in the Eleventh Amendment context. *E.g.*, *Koslow v. Pennsylvania*, 158 F. Supp. 2d 539, 544 (E.D. Pa. May 31, 2001) *vacated* (June 5, 2001), *reconsideration denied* (July 31, 2001) (rejecting former employee’s allegation that his state employer violated the RA thereby waiving its Eleventh Amendment immunity, even though state employer received federal funds); *Castro Ortiz v. Fajardo*, 133 F. Supp. 2d 143, 150 n.6 (D. P.R. 2001) (noting that “[p]laintiff[’]s claims under the Rehabilitation Act, although barred . . . because of lack of exhaustion of administrative remedies, on the merits would have suffered the same treatment of dismissal as to monetary damages based on the cases of [*Garrett and Kimel*].” (citations omitted)); *Garcia v. S.U.N.Y. Health Sci. Ctr.*, 280 F.3d 98, 114-15 (2d Cir. 2001) (holding that New York did not waive its sovereign immunity to suit under Section 504 of the Rehabilitation Act when it accepted federal funds). *See also* *New Holland Vill. Condo. v. Destaso Enters. Ltd.*, 139 F. Supp. 2d 499, 502 (S.D.N.Y. 2001) (“There is little, if any, room under this stringent standard . . . for the sort of ‘constructive’ waiver of immunity that plaintiff asks this court to apply based on [defendant’s] receipt of Federal funds under the Act.”). *Contra* ; *Jim C. v. United States*, 235 F.3d 1079, 1082 (8th Cir. 2000). *Frederick L. v. Dep’t of Pub. Welfare*, 157 F. Supp. 2d 509, 520-21 (E.D. Pa. 2001)

However, in different contexts, waiver has been found. As an example, waiver has been found in cases involving the Telecommunications Act of 1996, 47 U.S.C. §151, where courts have found that the *College Savings Bank* decision permitted waiver based on a state’s receipt of federal funds and permitted constructive waiver based on a state’s voluntary conduct in regulating telecommunications affairs. *AT&T Commc’n v. BellSouth Telecomm., Inc.*, 238 F.3d 636, 645 (5th Cir. 2001); *MCI Telecomm. Corp. v. Illinois Bell Tel. Co.*, 222 F.3d 323, 344 (7th Cir. 2000), *cert. denied*, 531 U.S. 1132 (2001) (“We believe that *College Savings* does not alter the principle that states may waive their immunity by accepting a benefit from Congress that has conditions attached”); *MCI Telecomm. Corp. v. Pub. Serv. Comm’n*, 216 F.3d 929, 937-38 (10th Cir. 2000), *cert. denied*, 531 U.S. 1183 (2001).

Savings Bank, Justice Scalia discussed the rationale behind the requirement of a “clear declaration”:

The whole point of requiring a “clear declaration” by the State of its waiver is to be certain that the State in fact consents to suit. But there is little reason to assume actual consent based upon the State’s mere presence in a field subject to congressional regulation. There is a fundamental difference between a State’s expressing unequivocally that it waives its immunity and Congress’s expressing unequivocally its intention that if the State takes certain action it shall be deemed to have waived that immunity. In the latter situation, the most that can be said with certainty is that the State has been put on notice that Congress intends to subject it to suits brought by individuals. That is very far from concluding that the State made an “all together voluntary” decision to waive its immunity.¹⁰⁴

IV. DECLARATORY JUDGMENT ACTIONS AGAINST THE FEDERAL GOVERNMENT IN FEDERAL COURT.

The federal government’s sovereign immunity is based upon the English Practice of granting sovereign immunity to the Crown.¹⁰⁵ When the American Constitution was ratified, it was well established in English law that the Crown could not be sued without consent in its own courts.¹⁰⁶

104. *Coll. Sav. Bank*, 527 U.S. at 680-81 (citations omitted).

105. *Alden v. Maine*, 527 U.S. 706, 715-16 (1999) (citing *Chisholm v. Georgia*, 2 Dall. 419, 437-446, 1 L.Ed. 440 (1793) (Iredell, J., dissenting), as surveying English practice). The preeminent authority on English law at the time, Sir William Blackstone, described the relationship between sovereignty and immunity as follows:

“And, first, the law ascribes to the king the attribute of sovereignty, or pre-eminence.... Hence it is, that no suit or action can be brought against the king, even in civil matters, because no court can have jurisdiction over him. For all jurisdiction implies superiority of power”

WILLIAM BLACKSTONE, 1 COMMENTARIES *234-35 (hereinafter “Blackstone”).

106. *Nevada v. Hall*, 440 U.S. 410, 414 (1979) (“The immunity of a truly independent sovereign from suit in its own courts has been enjoyed as a matter of absolute right for centuries. Only the sovereign’s own consent could qualify the absolute character of that immunity”).

Sovereign immunity has its origins in the feudal system.¹⁰⁷ As part of the feudal system, a lord could not be sued by a vassal in his own court.¹⁰⁸ However, a petty lord could be sued in the courts of a higher lord.¹⁰⁹ The King's court was the highest court in the land. Consequently, there was no higher court where the King could be sued.¹¹⁰ Sovereign immunity not only rested on the structure of the feudal system, but also on the fiction that the King could do no wrong.¹¹¹ The Supreme Court has rejected the concept that sovereign immunity is based upon the principle that the sovereign can do no wrong.¹¹²

"Although the American people had rejected other aspects of English political theory, the doctrine that a sovereign could not be sued without its consent was universal in the States when the Constitution was drafted and ratified."¹¹³ In adopting our federal system, the founding fathers considered immunity from private lawsuits central to sovereign dignity.¹¹⁴

107. *Id.*

108. *Id.* at 414-15 n.6 ("He can not be compelled to answer in his own court, but this is true of every petty lord of every petty manor; that there happens to be in this world no court above his court is, we may say, an accident." (citing 1 F. POLLOCK & F. MAITLAND, *HISTORY OF ENGLISH LAW* 518 (2d ed. 1899))); Engdahl, *Immunity and Accountability for Positive Governmental Wrongs*, 44 U. COLO. L. REV. 1, 2-5 (1972).

109. *Nevada*, 440 U.S. at 415 & n.6.

110. *Id.*

111. *Id.* at 415 & n.7 ("The king, moreover, is not only incapable of doing wrong, but even thinking wrong; he can never mean to do an improper thing." (quoting WILLIAM BLACKSTONE, *COMMENTARIES ON THE LAW OF ENGLAND* 246 (William S. Hein & Co, 1992) (1765))).

112. *Id.* at 415 & n.8 (the Supreme Court based this holding on the colonies rejection of the principle because the Declaration of Independence referenced the repeated wrongs inflicted by the Crown on the colonies) ("The Declaration of Independence proclaims: '[T]hat whenever any form of government becomes destructive of these ends, it is the right of the People to alter or to abolish it, and to institute new government . . . and such is now the necessity which constrains them to alter their former systems of government. The history of the present King of Great Britain is a history of repeated injuries and usurpations, all having in direct object the establishment of an absolute tyranny over these states'." (citing B. BAILYN, *THE IDEOLOGICAL ORIGINS OF THE AMERICAN REVOLUTION* 198-229 (1967))).

113. *Alden v. Maine*, 527 U.S. 715, 716 (1999) (citing *Chisholm v. Georgia*, 2 U.S. 419, 434-435 (Iredell, J., dissenting) ("I believe there is no doubt that neither in the State now in question, nor in any other in the Union, any particular Legislative mode, authorizing a compulsory suit for the recovery of money against a State, was in being either when the Constitution was adopted, or at the time the judicial act was passed.")); *See also* *Hans v. Louisiana*, 134 U.S. 1, 16 (1890) ("The suability of a State, without its consent, was a thing unknown to the law. This has been so often laid down and acknowledged by courts and jurists that it is hardly necessary to be formally asserted").

114. *Alden*, 527 U.S. at 716.

The United States, as sovereign, is immune from a lawsuit except when it consents to be sued.¹¹⁵ The terms of its consent to be sued defines that court's jurisdiction to entertain the lawsuit.¹¹⁶ Pursuant to the Tucker Act, 28 U.S.C. § 1491, the United States has sovereign immunity for claims for damages against it in excess of \$10,000 unless the claim is brought in the Court of Federal Claims.¹¹⁷ The Little Tucker Act gives district courts concurrent jurisdiction with the Court of Federal Claims in most Tucker Act cases seeking less than \$10,000.¹¹⁸ Claims in excess of \$10,000 cannot be brought in a district court.¹¹⁹ The Court of Federal Claims has exclusive jurisdiction over such claims.¹²⁰ Appeals of Little Tucker Act claims brought in district court are taken to the Federal Circuit, not the district court's geographical Court of Appeals.¹²¹

A lawsuit is considered against the United States regardless of whether or not the United States is a named defendant if 'the judgment sought would expend itself on the public treasury or domain'.¹²² A lawsuit is also considered against the United States when the judgment interferes with public administration, or when the judgment's effect is to compel or restrain the government's actions.¹²³

115. *Nevada*, 440 U.S. at 415 ("Only the sovereign's own consent could qualify the absolute character of that immunity.").

116. 28 U.S.C. § 1331 (2000) (the Federal Question statute merely establishes the subject matter jurisdiction of federal courts over federal claims that are within the competence of federal courts to entertain and does not generally waive sovereign immunity); *United States v. Mitchell*, 445 U.S. 535, 538 (1980); *Whittle v. United States*, 7 F.3d 1259, 1262 (6th Cir. 1993).

117. 28 U.S.C. § 1491(a)(1) (2000). The Tucker Act gives the United States Court of Federal Claims jurisdiction to render judgment upon any claim against the United States founded either upon the Constitution, or any Act of Congress or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort. *Id.*

118. *Kidwell v. Dep't of Army, Bd. for Corr. of Military Records*, 56 F.3d 279, 283 (D.C. Cir. 1995) (citing 28 U.S.C. § 1346(a)(2) (1988)).

119. *Cf. Van Drasek v. Lehman*, 762 F.2d 1065, 1071 n.10 (D.C. Cir. 1985) (noting that so-called "exclusive jurisdiction" of Court of Federal Claims over Tucker Act claims depends not on language of the Tucker Act, but on fact that Congress rarely grants district courts jurisdiction over such claims).

120. *Bowen v. Massachusetts*, 487 U.S. 879, 910 n.48 (1988).

121. *See* 28 U.S.C. § 1295(a)(2) (2000).

122. *Clark v. United States*, 691 F.2d 837, 839, 840 (7th Cir. 1982) (quoting *Land v. Dollar*, 330 U.S. 731, 738 (1947)).

123. *Dugan v. Rank*, 372 U.S. 609, 620 (1963); *Oladipupo v. Austin*, 104 F.Supp.2d 623, 624 (W.D. La. 2000) (suit against federal official in his or her official capacity is suit against United States). In deciding whether a suit against an officer for non-monetary relief

The issue of declaratory relief poses a different situation. A district court does not have jurisdiction merely because a lawsuit fails to seek monetary relief.¹²⁴ Courts recognize that plaintiffs may seek to bypass the Tucker Act jurisdiction by converting complaints which “at their essence” seek money damages from the government into complaints requesting injunctive relief or declaratory actions.¹²⁵ In order to prevent forum shopping which circumvents a primary purpose of the Tucker Act and to ensure that a central judicial body adjudicates most claims against the United States Treasury, “[j]urisdiction under the Tucker Act cannot be avoided by ... disguising a money claim” as a claim requesting a form of equitable relief.¹²⁶ Absent other grounds for district court jurisdiction, a claim is subject to the Tucker Act and its jurisdictional consequences if, in whole or in part, it explicitly or “in essence” seeks more than \$10,000 in monetary relief from the federal government.¹²⁷

Courts will look to the complaint’s substance, not merely its form to determine if a complaint is in essence seeking monetary damages when it is styled as seeking equitable relief.¹²⁸ A complaint does not “in essence” seek monetary relief merely because it hints at some interest in a monetary reward from the federal government or because success on the merits may obligate the United States to pay the complainant.¹²⁹ So long as the complaint only requests non-monetary relief that has “considerable value”

is in essence a suit against the United States, a court would engage in the legal fiction that a suit against a government officer in his official capacity is not a suit against the sovereign if (1) the government officer’s powers in his official capacity are limited by statute and his actions were ultra vires, or (2) the officer was acting unconstitutionally or pursuant to an unconstitutional grant of power from the sovereign. *Larson v. Domestic & Foreign Commerce Corp.*, 337 U.S. 682, 689-90 (1949).

124. *See, e.g., Megapulse, Inc. v. Lewis*, 672 F.2d 959, 967-68 (D.C. Cir. 1982); see also *Bowen*, 487 U.S. at 916 (Scalia, J., dissenting) (Relying on multiple federal authorities) (“[D]istrict court jurisdiction is not established merely because a suit fails to pray for a money judgment.” (citing cases)).

125. *Megapulse*, 672 F.2d at 968.

126. *Van Drasek*, 762 F.2d at 1071 n.11. *See also, United States v. Hohri*, 482 U.S. 64, 71-73 (1987) (describing goal of uniformity behind creation of Federal Circuit); *Vietnam Veterans of Am. v. Sec’y of the Navy*, 843 F.2d 528, 534 (D.C. Cir. 1988) (recognizing the Tucker Act’s interest in uniformity).

127. *Megapulse*, 672 F.2d at 967-68; *Heller, Ehrman, White & MacAuliffe v. Babbitt*, 992 F.2d 360, 363 (D.C. Cir. 1993) (Plaintiffs “may not, by creatively framing their complaint, circumvent a congressional grant of exclusive jurisdiction.”).

128. *See, e.g., Amoco Prod. Co. v. Hodel*, 815 F.2d 352, 361 (5th Cir. 1987).

129. *Vietnam Veterans*, 843 F.2d at 534 (“It is ... clear that a claim is not for money merely because its success may lead to pecuniary costs for the government or benefits for the plaintiff.”).

independent of any future potential for monetary relief, that is, as long as the sole remedy requested is declaratory or injunctive relief that is not “negligible in comparison” with the potential monetary recovery, courts will respect the party’s choice of remedies and treat the complaint as something more than an artfully drafted effort to circumvent the jurisdiction of the Court of Federal Claims.¹³⁰ In such cases, even if a complaint is filed with a desire to seek a future monetary award, a district court with otherwise appropriate jurisdiction may hear the claim and grant the proper equitable relief.¹³¹

Congress enacted the FDJA in 1934, thereby authorizing federal courts to grant federal declaratory judgment relief.¹³² The FDJA provides in relevant part:

In a case of actual controversy within its jurisdiction ... any court of the United States, upon the filing of an appropriate pleading, may declare the rights and other legal relations of any interested party seeking declaration, whether or not further relief is or could be sought. Any such declaration shall have the force and effect of a final judgment or decree and shall be reviewable as such.¹³³

Federal jurisdiction under the FDJA is based solely upon the original jurisdiction of the court, namely diversity jurisdiction or federal question jurisdiction.¹³⁴ District courts have discretion to exercise jurisdiction over

130. See e.g., *Kidwell v. Dep’t of Army, Bd. for Corr. of Military Records*, 56 F.3d 279, 283-286 (D.C. Cir. 1995); *Francis E. Heydt Co. v. United States*, 948 F.2d 672, 677 (10th Cir. 1991); *Hahn v. United States*, 757 F.2d 581, 589 (3d Cir. 1985) (concluding that district court did not have jurisdiction over request for money damages in complaint, but allowing it to retain jurisdiction over non-monetary claims also requested); cf. *Vietnam Veterans*, 843 F.2d at 535 (noting that courts are divided, in cases where plaintiffs request both monetary and equitable relief, over whether Court of Federal Claims jurisdiction precludes district court from hearing simultaneous request for equitable relief or vice-versa, and that this court has not decided issue).

131. *Kidwell*, 56 F.3d at 284; but see *Vietnam Veterans*, 843 F.2d at 535 (noting, but not deciding, that pursuit of equitable relief in district court may preclude plaintiff from later seeking monetary relief in Court of Federal Claims).

132. See *Id.*

133. *Id.*

134. 28 U.S.C. § 2201(a) (2001).

declaratory judgment actions brought under the FDJA.¹³⁵ The discretion granted under the FDJA is not unfettered. A district court cannot decline to entertain a declaratory judgment action as a matter of whim or personal disinclination.¹³⁶ The discretion granted by the FDJA essentially builds the abstention doctrine into this grant of jurisdiction.¹³⁷

In a declaratory judgment action involving coverage there is generally no request for monetary relief against the federal government. Instead, the carrier is seeking a declaration of rights under the policy. Unlike most previously decided cases where the plaintiff seeks declaratory relief with a desire to obtain monetary relief in the future, a carrier generally is not seeking monetary relief in the future. In fact, if the carrier is successful in seeking declaratory relief that the policy does not provide coverage, then no money would be exchanged. Even if the carrier is unsuccessful in seeking declaratory relief, the carrier would be responsible for any monetary award and not the federal treasury. This distinction, however, does not necessarily allow the carrier to sue the federal government.

The Tucker Act is “only a jurisdictional statute; it does not create any substantive right enforceable against the United States for money damages.”¹³⁸ A party must rely on some other independent, substantive right enforceable against the United States for money damages.¹³⁹ Various statutes address whether the federal government has waived its sovereignty.¹⁴⁰ No statute specifically confers jurisdiction over a declaratory judgment action against the federal government.

A similar issue was addressed by the Fifth Circuit Court of Appeals in *Anderson v. United States*.¹⁴¹ In *Anderson*, the trustees of the Hermann Hospital Estate filed a lawsuit against the United States and the Veterans Administration seeking declaratory relief to determine the rights and legal relations of the parties with reference to a parcel of land that had been condemned and appropriated for public use. The complaint alleged

135. *Wilton v. Seven Falls Co.*, 515 U.S. 277, 282 (1995) (“*Brillhart* makes clear that District Courts possess discretion in determining whether and when to entertain an action under the [Federal] Declaratory Judgment Act”).

136. *Gov’t Employees Ins. Co. v. Dizol*, 133 F.3d 1220, 1223 (9th Cir. 1998).

137. *See Wilton*, 515 U.S. at 282.

138. *United States v. Testan*, 424 U.S. 392, 398 (1976).

139. *Rogers v. United States*, 697 F.2d 886, 887 n.2 (9th Cir. 1983).

140. *See generally* 14 Charles Alan Wright, Arthur R. Miller & Edward H. Cooper, *Federal Practice and Procedure* § 3656 (3d ed. 1998) for a discussion of statutory exceptions to sovereign immunity in actions against the United States.

141. *Anderson v. United States*, 229 F.2d 675, 677 (5th Cir. 1956) 229 F.2d 675, 677 (5th Cir. 1956).

jurisdiction pursuant to 28 U.S.C. § 1331, which confers original jurisdiction on the district courts of all civil actions wherein the matter in controversy exceeds a specified sum and arises under the constitution, laws, or treaties of the United States. The Fifth Circuit held that the plaintiff could not rely upon Section 1331 because the United States cannot be sued without its consent. In addition, the Fifth Circuit noted that the plaintiffs did not allege a claim for money damages cognizable under 28 U.S.C. § 1346(a)(2) and that there was no statute authorizing an injunction against the United States.¹⁴² Furthermore, the Court held that the Federal Declaratory Judgments Act, 28 U.S.C. § 2201, did not grant any consent to sue the United States.¹⁴³ Consequently, the Court affirmed the dismissal of the case, reasoning that the United States had never consented to be sued in an action.

As discussed in *Anderson*, the Federal Declaratory Judgment Act empowers federal courts to give declaratory judgments in “a case of actual controversy within its jurisdiction,” but it is not an independent grant of jurisdiction.¹⁴⁴ Rather, federal jurisdiction must be predicated on some other statute.¹⁴⁵ Consequently, the Federal Declaratory Judgment Act is not a source of waiver of sovereign immunity that would allow a carrier to sue the federal government in federal court.

Section 702 of the Administrative Procedure Act (“APA”), 5 U.S.C. § 701 et seq., contains a limited waiver of the United States’ sovereign immunity. Section 702 provides in pertinent part:

A person suffering legal wrong because of agency action, or adversely affected or aggrieved by agency action within the meaning of a relevant statute, is entitled to judicial review thereof. An action ... seeking relief other than money damages ... shall not be dismissed ... on the ground that it is against the United States.

142. *Id.* (citing *Belknap v. Schild*, 161 U.S. 10; *Larson v. Domestic & Foreign Commerce Corp.*, 337 U.S. 682, 703).

143. *Id.* (citing *Love v. United States*, 108 F.2d 43 (8th Cir. 1939), *Blackmar v. Guerre*, 342 U.S. 512, 515-16 (1952), *Trueman Fertilizer Co. v. Larson*, 196 F.2d 910 (5th Cir. 1952), and *Mitchell v. United States*, 111 F.Supp. 104, 105 (D.N.J. 1952)).

144. *Rueth v. United States EPA*, 13 F.3d 227, 231 (7th Cir. 1993) (holding that federal court lacked jurisdiction under the Clean Water Act to review EPA's pre-enforcement actions and that court could not grant declaratory relief).

145. *Id.*

Agency action for purposes of the APA is defined as “the whole or a part of an agency rule, order, license, sanction, relief, or the equivalent or denial thereof, or failure to act”.¹⁴⁶ The APA may be relevant in cases where the underlying litigation is filed by the United States at the request of a federal agency. An insured, for example, may violate a federal law like the Clean Water Act, 33 U.S.C. § 1319. The administrator of the United States Environmental Protection Agency (“EPA”) may seek to obtain injunctive relief and criminal penalties for alleged violations of the Clean Water Act and request that the Justice Department file a lawsuit against the insured. The filing of the lawsuit could constitute “agency action” for purpose of the APA. It is axiomatic that the insured is an aggrieved party by the EPA’s decision to seek injunctive relief and criminal penalties. Pursuant to state law in certain jurisdictions, an insurance company may be the real party in interest in liability cases where the conduct of the insured may operate to impair or impede the insurance company’s ability to protect its own interest with respect to the insurance policy under which coverage is claimed.¹⁴⁷ Federal courts also recognize the insurer’s real party of interest status.¹⁴⁸ Although no cases have specifically addressed the issue, it can be argued that the carrier is the real party in interest in the lawsuit filed by the Justice Department at the behest of the EPA and that the carrier is also aggrieved by the agency’s decision and has standing to seek review under the APA. Because the APA contains a broad waiver to government sovereign immunity in agency review actions seeking declaratory and injunctive relief,¹⁴⁹ the APA would constitute an independent basis for jurisdiction in a lawsuit against the federal government.¹⁵⁰

146. See 5 U.S.C. § 551(13) and 5 U.S.C. § 701(b)(2) (2000) (“For the purpose of this chapter ... ‘agency action’ ha[s] the meanin[g] given ... by section 551 of this title”).

147. See, e.g., *Comacho v. Gardner*, 456 P.2d 925 (Ariz. 1969); *East v. Hedges*, 608 P.2d 327 (Ariz. Ct. App. 1980).

148. *Ocean Ships, Inc. v. Stiles*, 315 F.3d 111, 116 (2d Cir. 2002) (discussing when an insurer is a real party in interest); *Ash v. Farwell*, 37 F.R.D. 553, 554-555 (D. Kan. 1965) (holding that when an accident involved an insured automobile the insurance company is actually, in fact, if not in law, the real party in interest in the litigation).

149. *Cheyenne-Arapaho Gaming Comm'n v. National Indian Gaming Com'n*, 214 F.Supp.2d 1155, 1167 (N.D. Okla. 2002).

150. Cf., *Voluntary Purchasing Groups, Inc. v. Reilly*, 889 F.2d 1380, 1389 (5th Cir. 1989) (holding that based upon the CERCLA statute, its structure, and legislative history, until the government initiates a cost-recovery action, a potential responsible party cannot obtain judicial review of the agency action under the APA).

In addition, a request for a declaratory judgment in the example given would not impose an intolerable burden on governmental functions.¹⁵¹ “A declaratory judgment is just that: a declaration of rights. It is not a coercive remedy like an injunction or a money judgment.”¹⁵² Consequently, sovereign immunity would not apply and would not preclude the carrier from seeking declaratory relief in federal court.¹⁵³

V. DECLARATORY JUDGMENT ACTION AGAINST THE FEDERAL GOVERNMENT IN STATE COURT.

As previously discussed, the United States, and its officers while acting in their official capacities, enjoy sovereign immunity. Thus, a state court only has jurisdiction over an officer of the federal government if the United States has waived its immunity by consenting to suit or if the officer has exceeded any statutory or constitutional authority.¹⁵⁴ “Federal courts generally deem a suit for specific relief, e.g., injunctive or declaratory relief, against a named officer of the United States to be a suit against the sovereign.”¹⁵⁵ However, the protection of public officials from the fear of civil damages is not a concern when the lawsuit is for declaratory and injunctive relief.¹⁵⁶ As previously discussed, it can be argued that the federal government waived its sovereign immunity under the APA for a declaratory judgment action. The issue is whether the federal government can be sued in state court under the APA.

Although Congress did not explicitly grant federal courts exclusive jurisdiction to entertain APA lawsuits, it has been held that the federal courts have exclusive jurisdiction over APA lawsuits.¹⁵⁷ In *Aminoil U. S.*

151. *Clark v. United States*, 691 F.2d 837, 841 n.5 (7th Cir. 1982).

152. *Id.* at 841.

153. *C.H. Sanders Co., Inc. v. BHAP Hous. Dev. Fund Co., Inc.*, 903 F.2d 114, 119 (2d Cir. 1990) (“We hold that an action (regardless of the amount sought) may be commenced under § 1331 in the district court provided there is an independent waiver of sovereign immunity outside the Tucker Act.”).

154. *See Aminoil U.S.A., Inc. v. Cal. State Water Res. Control Bd.*, 674 F.2d 1227, 1233 (9th Cir. 1982).

155. *Wyoming v. United States*, 279 F.3d 1214, 1225 (10th Cir. 2002) (citing *Larson v. Domestic & Foreign Commerce Corp.*, 337 U.S. 682, 688 (1949)).

156. *See B. C. Morton Int’l Corp. v. Fed. Deposit Ins. Corp.*, 305 F.2d 692, 695-96 (1st Cir. 1962).

157. *See Aminoil U.S.A., Inc.*, 674 F.2d at 1235 (9th Cir. 1982); 2 FED. PROC. L. ED. § 2:267 (2006) (“It is not proper to permit a state court to review the decisions of federal agencies under the APA when, in fact, the APA provides no independent basis for federal jurisdiction and should provide no independent cause of action in state court either.”). *But*

A., Inc. v. California State Water Resources Control Board,¹⁵⁸ for example, Aminoil operated oil and gas wells at a site in Orange County, California. The various operations produced drilling wastes that were discharged into the surrounding environment. The Fish and Wildlife Service of the United States Department of the Interior requested that the Santa Ana Region of the State Board (Regional Board) adopt an order declaring Aminoil's disposal site a "wetlands" subject to the jurisdiction of the Clean Water Act¹⁵⁹ and its companion California statute.¹⁶⁰ The EPA and the Regional Board concluded that the disposal site could not be defined as national wetlands and, therefore, a permit for the discharge of pollutants into navigable waters was not necessary. An environment group appealed the decision to the California State Water Resources Control Board ("State Board"), which reversed the decision.

Aminoil originally filed a lawsuit in California state court to review the order of the State Board and joined the Administrator of the EPA as a real party in interest. The Administrator removed the case to the district court pursuant to 28 U.S.C. § 1442(a)(1). Upon removal, the Administrator filed a motion to dismiss, asserting that neither the state court, nor the district court upon removal, had jurisdiction to entertain the lawsuit because of sovereign immunity. The district court granted the motion, holding that a state court does not have jurisdiction over a federal agency in a dispute over federal law when the federal court lacked jurisdiction.¹⁶¹

The Ninth Circuit Court of Appeals held that, although the State court had general jurisdiction over Aminoil's cause of action against the State Board, the State Court may not necessarily have the power to join the Administrator as a party. The Ninth Circuit reasoned that it is well settled that the United States, and its officers while acting in their official capacities, enjoy sovereign immunity. The Ninth Circuit noted that a State court may entertain an action against an officer of the federal government

see Gulf Offshore Co. v. Mobil Oil Corp., 101 S.Ct. 2870, 2875-76(1981) ("[T]he mere grant of jurisdiction to a federal court does not operate to oust a state court from concurrent jurisdiction over the cause of action.").

158. 674 F.2d 1227 (9th Cir. 1982).

159. 33 U.S.C. §§ 1251-1376 (2000).

160. CAL. WATER CODE § 13320 (West 1992).

161. *Aminoil U.S.A. Inc.*, 674 F.2d at 1231 n.3. (District court held that the EPA must take final action before it can be sued pursuant to the Clean Water Act, and that when the EPA is sued, it must be sued in federal court).

only if the United States has waived its immunity by consenting to suit or if the officer has exceeded his statutory or constitutional authority.¹⁶²

On appeal, *Aminoil* argued, among other things, that Section 702 of the APA applied and that the federal government waived its sovereign immunity. The Ninth Circuit held that Section 702 was clearly inapplicable. The Court noted that while Section 702 waives the sovereign immunity of the United States for non-monetary claims against the government, the waiver of sovereign immunity is expressly limited to actions brought “in a court of the United States ...”¹⁶³ The Court based its decision on the legislative history of the APA which demonstrated that Section 702 was not intended to effect a waiver of sovereign immunity for suits against the United States or its officers in state courts.¹⁶⁴ Consequently, there is no state forum for a declaratory judgment action against the federal government.¹⁶⁵

VI. DECLARATORY JUDGMENT ACTION AGAINST STATE IN FEDERAL COURT.

The Eleventh Amendment was enacted to delineate the scope of sovereign immunity reserved by the States.¹⁶⁶ The Eleventh Amendment provides, “The Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one

162. *Id.* at 1233. See also *Dugan v. Rank*, 372 U.S. 609, 623 (1963); *United States v. Sherwood*, 312 U.S. 584, 586 (1941); *Martinez v. Marshall*, 573 F.2d 555, 560 (9th Cir. 1977); *Smith v. Grimm*, 534 F.2d 1346, 1351 n.6 (9th Cir. 1976).

163. *Aminoil U.S.A. Inc.*, 674 F.2d at 1233 (citing *Hill v. United States*, 571 F.2d 1098, 1102 (9th Cir. 1978)).

164. *Aminoil U.S.A. Corp.*, 674 F.2d at 1233 (quoting H.R. REP. NO. 94-1656, at 11 (1976), as reprinted in (1976) U.S.C.C.A.N. 6121, 6131 (“The consent to suit is also limited to claims in the courts of the United States; hence, the United States remains immune from suit in state courts.”)).

165. In *Aminoil*, the Ninth Circuit also held that the removal of the state case to federal court did not confer jurisdiction on the district court because removal jurisdiction is entirely derivative of the jurisdiction of the state court. *Id.* at 1232 (citing *Minnesota v. United States*, 305 U.S. 382, 389 (1939)). The Ninth Circuit reasoned that when the state court lacks jurisdiction, the district court does not acquire jurisdiction even if it would have had jurisdiction if the suit had originally been commenced in federal court. *Id.* (citing *Lambert Run Coal Co. v. Balt. & Ohio R. Co.*, 258 U.S. 377, 382 (1922); *Jacobson v. Tahoe Reg'l Planning Agency*, 566 F.2d 1353, 1362 (9th Cir. 1977)).

166. See *Alden v. Maine*, 527 U.S. 706, 723 (1999).

of the United States by Citizens of another State, or by Citizens or Subjects of any Foreign State.”¹⁶⁷

The Eleventh Amendment guarantees that non-consenting states may not be sued by private individuals in federal court.¹⁶⁸ Thus, States are immune from suits brought in federal court by their own citizens, and the citizens of other States.¹⁶⁹ “The Eleventh Amendment bar is not absolute. States may consent to suit in federal court and, in certain cases, Congress may abrogate the States’ sovereign immunity.”¹⁷⁰

Federal courts will give effect to a State’s waiver of Eleventh Amendment immunity “only where stated by the most express language or by such overwhelming implication from the text as [will] leave no room for any other reasonable construction.”¹⁷¹ “A State does not waive its Eleventh Amendment immunity by consenting to suit only in its own courts.”¹⁷² “Thus, in order for a state statute or constitutional provision to constitute a waiver of Eleventh Amendment immunity, it must specify the State’s intention to subject itself to suit in *federal court*.”¹⁷³

States generally maintain their absolute and qualified sovereign immunity in various, enumerated circumstances by statute which may not be applicable to a particular declaratory judgment action.¹⁷⁴ If the State, for example, sues the insured in State court, the filing of the suit does not waive the State sovereign immunity in federal court. States typically do not specifically consent to being sued in federal court. States may typically authorize tort and contract actions against the State.¹⁷⁵ Such limited waivers of its sovereign immunity do not waive the State’s sovereign immunity such that it can be sued in federal court.¹⁷⁶

Congress can abrogate the State’s immunity pursuant to a valid exercise of power, hence allowing a State to be sued in federal court.¹⁷⁷

167. U.S. CONST., amend. XI.

168. *Bd. of Trs. of the Univ. of Ala. v. Garrett*, 531 U.S. 356, 363 (2000).

169. *Edelman v. Jordan*, 415 U.S. 651, 662-63 (1974). *See also*, *Bd. of Trs. of the Univ. of Ala. v. Garrett*, 531 U.S. at 363; *Kimel v. Fla. Bd. of Regents*, 528 U.S. 62, 72-73 (2000); *Hans v. Louisiana*, 134 U.S. 1, 15 (1890).

170. *Port Auth. Trans-Hudson Corp. v. Feeney*, 495 U.S. 299, 304 (1990).

171. *Atascadero State Hosp. v. Scanlon*, 473 U.S. 234, 239-40 (1985) (internal quotations omitted).

172. *Port Auth. Trans-Hudson Corp.*, 495 U.S. at 306.

173. *Atascadero State Hosp.*, 473 U.S. at 241.

174. *See, e.g.*, ARIZ. REV. STAT. § 12-820.01 (2006).

175. *See, e.g.*, ARIZ. REV. STAT. § 12-821 (2007).

176. *Markowitz v. United States*, 650 F.2d 205, 206 (9th Cir. 1981).

177. *See Fitzpatrick v. Bitzer*, 427 U.S. 445, 445-46 (1976).

According to the *Ex Parte* Young doctrine, a State can be sued in federal court by a plaintiff seeking injunctive relief in a suit against a state official.¹⁷⁸ However, the *Ex Parte* Young doctrine only applies when “the relief sought is prospective in nature *and* is based on an ongoing violation of the plaintiff’s *federal* constitutional or statutory rights.”¹⁷⁹ The Eleventh Amendment also bar claims in federal court asserted against state officers based on alleged violations of state law.¹⁸⁰

A lawsuit filed by the State for violations of state environmental laws would typically not contain any federal issues. Consequently, the *Ex Parte* Young doctrine would be inapplicable and a federal forum is unavailable for a declaratory judgment action involving the state government.

In addition, when “a corporation of one state sues another state, the action is deemed not to be between citizens of different states, and diversity of citizenship is therefore unavailable as a basis for federal jurisdiction.”¹⁸¹

VII. DECLARATORY JUDGMENT ACTION AGAINST STATE GOVERNMENT IN STATE COURT.

The Eleventh Amendment, does not bar a suit against a State in that State’s own court system nor does it bar a suit against a state in a different State court.¹⁸² Most States have adopted the Uniform Declaratory Judgments Act. Arizona’s Declaratory Judgment Act, A.R.S. § 12-1832, presents as a typical enactment of the Uniform Declaratory Judgments Act. A.R.S. § 12-1832 provides:

Any person interested under a deed, will, written contract or other writings constituting a contract, or whose rights, status or other legal relations are affected by a statute, municipal ordinance, contract or franchise, may have determined any question of construction or validity arising under the instrument, statute, ordinance, contract, or

178. *Ex Parte* Young, 209 U.S. 123, 166-67 (1908).

179. *Cent. Reserve Life of N. Am. Ins. Co. v. Struve*, 852 F.2d 1158, 1161 (9th Cir. 1988) (first emphasis added). See *Charley’s Taxi Radio Dispatch Corp. v. Sida of Haw., Inc.*, 810 F.2d 869, 874 (9th Cir. 1987).

180. *Pennhurst State Sch. & Hosp. v. Halderman*, 465 U.S. 89, 106 (1984).

181. *Cent. Reserve Life of N. Am. Ins. Co.*, 852 F.2d at 1161 n.5 (citing *State Highway Comm’n of Wyo. v. Utah Constr. Co.*, 278 U.S. 194, 200 (1928)).

182. *Nevada v. Hall*, 440 U.S. 410, 411 (1979).

franchise and obtain a declaration of rights, status or other legal relations thereunder.

Arizona courts, like most jurisdictions, have held that the Arizona Declaratory Judgment Act is a means by which a party may seek declaratory judgment relief to resolve controversies involving public officials.¹⁸³ In addition, declaratory relief is available to insureds, insurers, and other parties whose rights, status, or legal relations are affected by an insurance policy.¹⁸⁴ Hence, based upon the State's enactment of its declaratory judgment act and its waiver of sovereign immunity, a carrier can seek declaratory relief against the State and its agencies in state court.

Based upon the relevant case law, a carrier typically cannot file one consolidated action involving the insured, the federal government, and the state government. A carrier must file two separate actions: one in federal court against the federal government and another in state court against the state government. Alternatively, the carrier may chose to file only one declaratory judgment action against either the federal government or the state government with the hopes that the other governmental entity may chose to intervene. If the governmental entity intervenes in a court where it has sovereign immunity, the governmental entity has waived its sovereign immunity and jurisdiction in the court is proper.¹⁸⁵

VIII. FULL FAITH AND CREDIT: A PRACTICAL APPROACH TO FINDING A WAY THROUGH THE MAZE OF DUAL SOVEREIGNTY

It is not possible to force both the federal government and state government into one single unified declaratory judgment action in either state or federal court. The question becomes whether there is a practical way to maneuver around the obstacle created through dual sovereignty to avoid the time and costs associated with bringing two separate actions, as

183. *Riley v. Cochise County*, 455 P.2d 1005, 1009 (Ariz. Ct. App. 1969).

184. *See Connolly v. Great Basin Ins. Co.*, 431 P.2d 921, 926-27 (Ariz. Ct. App. 1967).

185. *Missouri v. Fiske*, 290 U.S. 18, 24 (1933) (noting that State's Eleventh Amendment Immunity may be waived by a voluntary proceeding in intervention, but holding no waiver under particular facts); *United States v. Tsosie*, 92 F.3d 1037, 1041 (10th Cir. 1996) (holding that federal government waived its sovereign immunity by initiating suit); *see also*, 6 CHARLES A. WRIGHT, ET AL., *Federal Practice and Procedure* § 1427, at 197 (2d ed. 1990) ("[W]hen the United States institutes an action, defendant may assert by way of recoupment any claim arising out of the same transaction or occurrence as the original claim in order to reduce or defeat the government's recovery.").

well as to avoid the possibility of inconsistent results on the same issue. One strategic approach to this problem may be found within the doctrines of full faith and credit and comity.

Article IV, § 1 of the United States Constitution provides that: "Full Faith and Credit shall be given in each State to the public Acts, Records, and judicial Proceedings of every other State ... Congress may by general Laws prescribe the Manner in which such Acts, Records and Proceedings shall be proved, and the Effect thereof."¹⁸⁶ Strictly speaking, the full faith and credit clause of the United States Constitution does not require that the federal courts give full faith and credit to the judgments of state courts.¹⁸⁷ Similarly, judgments of the federal courts are generally not considered to be within the purview of the constitutional requirement that state courts to give full faith and credit to judgments from other states.¹⁸⁸

However, all federal courts are required by statute to give full faith and credit to valid state court judgments.¹⁸⁹ Specifically, pursuant to 28 U.S.C. § 1738, "[t]he records and judicial proceedings of any court of any ... State, Territory, or Possession of the United States, or copies thereof, ... shall have the same full faith and credit in every court within the United States and its Territories and Possessions as they have by law or usage in the courts of [the] State, Territory, or Possession from which they are

186. 28 U.S.C.A. § 1738 (West 2007) (duly authenticated "records and judicial proceedings of any court of any such State, Territory or Possession, or copies thereof ... shall have the same full faith and credit in every court within the United States and its Territories and Possessions as they have by law or usage in the court[] [from] which they [were] taken.").

187. *Univ. of Tenn. v. Elliott*, 478 U.S. 788, 799 (1986); *Taylor v. Sawyer*, 284 F.3d 1143, 1152 (9th Cir. 2002) (stating that "[b]y its terms, and in light of its purpose, the Full Faith and Credit Clause imposes no obligation whatsoever on the federal government."); *United States v. Carter*, No. 05-5179, 2006 WL 2076807 at *3 (10th Cir. Jul. 27, 2006).

188. *Supreme Lodge, K.P. v. Meyer*, 265 U.S. 30, 33 (1924); *Del. Valley Citizens' Council for Clean Air v. Com. of Pa.*, 755 F.2d 38, 43 (3d Cir. 1985); *Puckett v. City of Emmett*, 747 P.2d 48 (Idaho 1987); *Thompson's Estate*, 339 Mo. 410, 97 S.W.2d 93 (1936).

189. *Noel v. Hall*, 341 F.3d 1148, 1160 (9th Cir. 2003) (stating that the Full Faith and Credit Act requires a federal district court to give the same, not more and not less, preclusive effect to a state court judgment as that judgment would have in the state courts of the state in which it was rendered); *Slip Track Systems, Inc. v. Metal-Lite, Inc.*, 304 F.3d 1256, 1262 (Fed. Cir. 2002) (stating that federal courts must give state court judgments full faith and credit by applying the preclusion law of the rendering state); *Genesys Data Technologies, Inc.*, 204 F.3d 124, 128 (4th Cir. 2000); *Cruz v. Melecio*, 204 F.3d 14, 18 (1st Cir. 2000) (observing that the statute granting full faith and credit to state judicial proceedings requires the federal courts to give the same preclusive effect to state court judgments that those judgments would be given in the courts of the state from which the judgments emerged).

taken.”¹⁹⁰ Thus, a federal court generally must give full faith and credit to a state court judgment, allowing it to have both res judicata¹⁹¹ and collateral estoppel effect.¹⁹²

Similarly, a state court must give a federal court judgment full faith and credit,¹⁹³ and thus both res judicata¹⁹⁴ and collateral estoppel effect.¹⁹⁵ Under the Uniform Enforcement of Foreign Judgments Act (UEFJA),¹⁹⁶ the term “foreign judgment” includes a judgment of any court of the United States.¹⁹⁷ Thus, a judgment of a federal district court comes within the purview of the UEFJA.¹⁹⁸ Under the UEFJA, a copy of a foreign judgment may be filed in a court of the state, in which case the judgment is treated as a judgment of a court of the state.¹⁹⁹

190. 28 U.S.C. A. § 1738 (West 2007).

191. *Pelletier v. Zweifel*, 921 F.2d 1465, 1501 (11th Cir. 1991); *Americana Fabrics, Inc. v. L & L Textiles, Inc.*, 754 F.2d 1524, 1529 (9th Cir. 1985).

192. *Allen v. McCurry*, 449 U.S. 90, 95-96 (1980); *Dixon v. Richer*, 922 F.2d 1456, 1459 (10th Cir. 1991).

193. *Meyer*, 265 U.S. at 33 (holding that “[w]hile the judicial proceedings of the federal courts are not within the terms of the constitutional provision, such proceedings, nevertheless, must be accorded the same full faith and credit by state courts as would be required in respect of the judicial proceedings of another state.”); *Sosa v. DIRECTV, Inc.*, 437 F.3d 923, 928 (9th Cir. 2006); *Delaware Valley Citizens' Council for Clean Air v. Com. of Pa.*, 755 F.2d 38, 43 (3d Cir. 1985) (stating that “although Congress implemented the Constitution's full faith and credit clause of Article IV, § 1, in language referring only to state courts, there ‘is a clearly established rule that state courts must give full faith and credit to the proceedings of federal courts[.] That this is the rule is beyond doubt, and the state courts have generally accepted it.’”); *Nottingham v. Weld*, 237 Va. 416, 419, 377 S.E.2d 621, 623 (Va. 1989); *McAllister*, 216 B.R. 957, 974 (Bankr. N.D.Ala. 1998); *Rehabilitation of Frontier Ins. Co.*, 27 A.D.3d 274, 275 (N.Y.App.Div. 2006); *Denny Wiekhorst Equip., Inc. v. Tri-State Outdoor Media Group, Inc.*, 693 N.W.2d 506, 511 (Neb. 2005); *Transamerica Trade Co., Inc. v. McCollum Aviation, Inc.*, 424 N.E.2d 740, 742 (Ill. Ct. App. 1981).

194. *Sosa v. DIRECTV, Inc.*, 437 F.3d 923, 928 (9th Cir. 2006); *S. Coatings, Inc. v. City of Tamarac*, 916 So.2d 19, 21 (Fla. Ct. App. 2005); *Federated Mgt. Co. v. Latham & Watkins*, 742 N.E.2d 684, 689 (Ohio Ct. App. 2000); *Urlic v. Insurance Co. of State of Pennsylvania*, 259 A.D.2d 1, 4 (N.Y.App.Div. 1999).

195. *Denny Wiekhorst Equip., Inc. v. Tri-State Outdoor Media Group, Inc.*, 693 N.W.2d 506, 511 (Neb. 2005); *McCallum v. N. C. Co-op. Extension Service of N.C. State Univ.*, 542 S.E.2d 227, 233 (N.C. Ct. App. 2001).

196. *Unif. Enforcement of Foreign Judgments Act* §§ 1-10 (West 2007).

197. *Id.* § 1.

198. *Bechtel Corp. v. W. Contracting Corp.*, 414 N.W.2d 130, 131 (Iowa 1987).

199. *Unif. Enforcement of Foreign Judgments Act of 1964* § 2 (West 2007). However, it is important to note that there is at least one state variation of the UEFJA Act that does not apply to federal court judgments. *Fed. Deposit Ins. Corp. v. Panelfab Intern. Corp.*, 501 So.2d 167, 168 (Fla.Disct.Ct. App. 1987).

The usefulness of the full faith and credit doctrine as it pertains to the subject matter of this article derives from the specific factual circumstances at issue. While it is not possible to bring both the state and federal governments into one unified action, the insured will be a part of the action irregardless of the forum. If the factual and legal issues pertaining to coverage are the same in relation to the claims by both the state and federal governments, any decision in favor of the insurance carrier against the insured should be given full faith and credit in either forum.

For example, if the insurance carrier proceeds against the insured and the federal government in a federal declaratory judgment action, the decision should be given full faith and credit in any subsequent state court proceeding. Technically speaking, because the state government was not a party to this proceeding, the state government would not be bound by the decision under either *res judicata* or collateral estoppel.²⁰⁰ However, the state government should, for all practical purposes, be bound to the judgment on the coverage issue via the decision against the insured. More specifically, any possible recovery which can be obtained against the insurance policy by the state government in relation to a judgment against the insured in state court can only occur if the insured is entitled to such coverage under the terms of the insurance contract. Since a judgment on the issue of coverage has already been rendered by the federal court under this scenario, the state court should be effectively precluded from recovering against the policy pursuant to the full faith and credit doctrine.

Arguably, the above should work whether the declaratory judgment action is filed in either state or federal court. However, the practical effect of the full faith and credit doctrine may be weaker as it pertains to the federal government giving full faith and credit to a decision of a state court. The federal full faith and credit statute may be subject to certain

200. It has been held that in order for a federal court judgment to have preclusive effect in a state court action the parties to the state court proceeding must be the same as the original federal court proceeding; the judgment is not binding on strangers but is conclusive only as against those parties or their privies or others who sufficiently participate or are represented in the action. *McCallum v. N.C. Co-op. Extension Serv. of N.C. State University*, 142 N.C.App. 48, 51-52, 542 S.E.2d 227, 231 (N.C. Ct. App. 2001); *Wagner v. Heavlin*, 136 Ohio App.3d 719, 738, 737 N.E.2d 989, 1002-03 (Ohio Ct. App. 2000); *Great Dane Trailer Sales, Inc. v. Malvern Pulpwood, Inc.*, 301 Ark. 436, 439, 785 S.W.2d 13, 15 (Ark. 1990); *Waddell v. Stevenson*, 683 S.W.2d 955, 958 (Ky. Ct. App. 1984); *Silver v. Queen's Hospital*, 63 Haw. 430, 435-36, 629 P.2d 1116, 1121 (Hawaii 1981).

exceptions,²⁰¹ and the effect of state court judgments may be limited by competing federal interests or public policy.²⁰²

In contrast, states do not appear to have such flexibility in applying the full faith and credit doctrine to federal court decisions.²⁰³ A judgment or decree which has been duly rendered by a federal court is binding and conclusive on the parties to that action in all subsequent state court litigation between them, and is not subject to review or reexamination by the state courts on the merits.²⁰⁴ Likewise, the procedural transfer of a federal court judgment to a state court pursuant to the UEFJA does not confer jurisdiction upon the state court to reconsider the merits of the case *de novo*.²⁰⁵ A judgment duly rendered by a federal court also cannot be

201. *Aquatherm Indus., Inc. v. Florida Power & Light Co.*, 84 F.3d 1388, 1392 (11th Cir. 1996); *Clements v. Airport Auth. of Washoe County*, 69 F.3d 321, 328 (9th Cir. 1995); *In re Hale*, 155 B.R. 730, 735 (S.D. Ohio 1993).

202. *U.S. v. ITT Rayonier, Inc.*, 627 F.2d 996, 1001-02 (9th Cir. 1980) (observing that in employment discrimination suits under Title VII of the 1964 Civil Rights Act, several courts have refused to give collateral estoppel effect to prior decisions by state agencies under state law because of the countervailing public policy that a plaintiff is not to be deprived of a federal forum to adjudicate employment discrimination claims); *Batiste v. Furnco Constr. Corp.*, 503 F.2d 447, 450 (7th Cir. 1974); *Matter of Shuler*, 722 F.2d 1253, 1258 n.10 (5th Cir. 1984).

203. *Fauntleroy v. Lum*, 210 U.S. 230, 237 (1908) (holding that the doctrine of full faith and credit required Mississippi to extend full faith and credit to a judgment obtained in Missouri upon a gambling debt even though that debt was incurred in Mississippi and such a debt was not a valid legally enforceable obligation under Mississippi law); *Hilton Intern. Co. v. Arace*, 35 Conn.Supp. 522, 530, 394 A.2d 739, 743 (Conn. Super. Ct. 1977); *see also* REST. (SECOND) OF CONFLICT OF LAWS § 117 (1971) (“[a] valid judgment rendered in one State of the United States will be recognized and enforced in a sister State even though the strong public policy of the latter State would have precluded recovery in its courts on the original claim.”).

204. *Prina v. Union Canal & Irr. Co.*, 63 Ariz. 473, 163 P.2d 683 (1945); *Meyer v. Milliken*, 111 Colo. 113, 138 P.2d 276 (1943); *Standard Accident Ins. Co. v. Simpson*, 151 Fla. 564, 10 So.2d 85 (1942); *Meyer v. Kenmore-Granville Hotel Co.*, 308 Ill.App. 78, 31 N.E.2d 330 (1941); *Union Pac. R. Co. v. Missouri Pac. R. Co.*, 136 Kan. 166, 13 P.2d 276 (1932); *Hays v. Lundy*, 293 Ky. 711, 170 S.W.2d 49 (1943); *Real Estate Exch. Corp. v. Harte*, 304 Mich. 596, 8 N.W.2d 652 (1943); *In re McLure's Estate*, 90 Mont. 502, 3 P.2d 1056 (1931); *Wehle v. Shanks*, 35 N.Y.S.2d 801 (1942); *Dittmar v. St. Louis Union Trust Co.*, 155 S.W.2d 388 (Tex. Ct. App. 1941); *State ex rel. O'Brien v. Superior Court for King County*, 173 Wash. 679, 24 P.2d 117 (1933).

205. *U.S. v. ITT Rayonier, Inc.*, 627 F.2d 996, 1001-02 (9th Cir. 1980) (observing that in employment discrimination suits under Title VII of the 1964 Civil Rights Act, several courts have refused to give collateral estoppel effect to prior decisions by state agencies under state law because of the countervailing public policy that a plaintiff is not to be deprived of a federal forum to adjudicate employment discrimination claims); *Batiste v. Furnco Const.*

impeached collaterally in a state court for any alleged irregularity or error.²⁰⁶ A state court can only reexamine a federal court judgment for purposes of determining the scope and extent of that judgment.²⁰⁷

This approach may find further support depending upon the facts and regulations at issue. Specifically, privity may be held to exist between the state and federal governments if the violations sued for and adjudicated in the federal case are the same as those presented in a state enforcement action.²⁰⁸ Although the state government may not be involved in the federal court action, if privity exists the state may nevertheless be bound by the decision under either *res judicata* or collateral estoppel because of the federal government's involvement.

For example, in *State Water Control Bd. v. Smithfield Foods, Inc.*,²⁰⁹ the insured, Smithfield Foods, Inc., was sued by both the EPA and the Virginia State Water Control Board in separate proceedings for violations of a permit that regulated the discharge of wastewater into navigable waters.²¹⁰ In the federal action brought by the EPA, it was determined that Smithfield had engaged in numerous violations of its permit.²¹¹ Smithfield subsequently filed a motion in the state action, asserting that the Virginia State Water Control Board's enforcement action in state court was now barred by the doctrine of *res judicata*.²¹² The central issue in that case was whether privity existed between the Virginia State Water Control Board and the EPA in the federal action. The Supreme Court of Virginia held that

Corp., 503 F.2d 447, 450 (7th Cir. 1974); *Tronagun Corp. v. Mizerock*, 820 F.Supp. 225 (W.D.Pa. 1993).

206. *Chapman v. Federal Land Bank of Louisville, Kentucky*, 117 F.2d 321 (6th Cir. 1941); *Mueller v. Elba Oil Co.*, 21 Cal.2d 188, 130 P.2d 961 (1942); *Standard Accident Ins. Co. v. Simpson*, 151 Fla. 564, 10 So.2d 85 (1942); *Union Pac. R. Co. v. Missouri Pac. R. Co.*, 136 Kan. 166, 13 P.2d 276 (1932); *Real Estate Exch. Corp. v. Harte*, 304 Mich. 596, 8 N.W.2d 652 (1943); *Cline v. Tait*, 113 Mont. 475, 129 P.2d 89 (1942); *U.S. v. President and Directors of Manhattan Co.*, 276 N.Y. 396, 12 N.E.2d 518 (1938); *Upton's Estate*, 199 Wash. 447, 92 P.2d 210 (1939).

207. *State v. St. Louis-San Francisco Ry. Co.*, 258 S.W. 609, 162 Ark. 443 (1924).

208. *See, e.g., State Water Control Bd. v. Smithfield Foods, Inc.*, 261 Va. 209, 215-16, 542 S.E.2d 766, 769-70 (2001). *Cf. ITT Rayonier, Inc.*, 627 F.2d at 1003 (holding that the relationship between the Environmental Protection Agency and the Washington Department of Ecology was sufficiently close such that the Environmental Protection Agency was collaterally estopped from re-litigating in a federal enforcement action under the Federal Water Pollution Control Act an issue which had already been decided in a state enforcement action in which the Washington Department of Ecology had been a party).

209. *State Water Control Bd.*, 542 S.E.2d 766.

210. *Id.* at 768.

211. *Id.*

212. *Id.*

privity existed in that case because the interests and rights of both the state and federal agencies were vested in a single permit issued pursuant to joint program between the agencies.²¹³ In other words, “the [Virginia State Water Control Board] and the EPA share[d] an identity of interest in the permit issued to Smithfield ... such that the [Virginia State Water Control Board’s] legal right was represented by the EPA in the federal action when the EPA sought to enforce the provisions of the permit.”²¹⁴

It should be noted that whether privity exists between the parties in particular circumstances requires a case by case determination in which the traditional principles of the doctrine are applied.²¹⁵ The mere existence of dual enforcement powers between the state and federal governments in and of itself neither compels nor precludes a finding of privity.²¹⁶ Nevertheless, it is another factor which may work in favor of the approach to solving the dilemma which is the subject matter of this article, as outlined above.

In sum, it would appear that the less problematic approach would be for the insurance carrier to file a declaratory judgment action in federal court against the insured and the federal government in these dual sovereignty situations. If the insurance carrier is successful on the relevant coverage issues, the state government should be effectively precluded from recovering under the policy due to the full faith and credit protection afforded to the decision rendered on coverage between the insurance carrier and the insured. Any state proceeding which may be necessary to enforce the federal judgment should be abbreviated, thereby avoiding the expense associated with prosecuting two separate actions. This should also effectively avoid the possibility of inconsistent decisions rendered on the same issue.

Practically speaking, taking this approach to resolve this dilemma could also operate to force the state government to consider voluntarily waiving its immunity and participate in the federal declaratory judgment action, thereby avoiding the dilemma altogether. If the state government is aware that the declaratory judgment action is proceeding and that a decision in that action could prevent the state from recovering under the policy, the state may seek to join the federal action in order to protect its interest in the resolution of the coverage issue.

213. *Id.* at 770.

214. *Id.*

215. *Id.* at 771.

216. *Id.*

I CAME, I SAW, I UNDERWROTE: D & O LIABILITY INSURANCE'S PAST UNDERWRITING PRACTICES AND POTENTIAL FUTURE DIRECTIONS

Joshua Dobiac

Underwriting is rarely easy. For D & O liability insurance underwriting this is even truer. A field that has long been recognized as more of an art than a science, many billions of dollars rest upon their accurately rating the risks that they underwrite. This paper attempts to evaluate the current practices of D & O insurance underwriting with one goal in mind: Is there a better way of underwriting the risk?

Part I of this paper provides a basic review of the D & O underwriting market and how underwriters go about underwriting risk, first in general and then specifically D & O risk. Part II evaluates the how corporate governance may be a compelling factor in individualized underwriting. Finally Part III discusses an alternative to the current underwriting methods, with the goal of making D & O insurance underwriting less prone to errors.

I. THE D & O INSURANCE MARKET AND D & O UNDERWRITERS

All states in the U.S. have statutes allowing for the indemnification of Directors and Officers.¹ Such indemnification is allowed even for those acts that the corporation is statutorily prevented from personally indemnifying.² While historically states were silent on whether this was allowed, it soon became apparent that this type of insurance was not going to go away.³ This was the beginning of Directors' and Officers' Insurance as a *bona fide* line of insurance.⁴

1. For a complete list, see Joseph Warren Bishop, *THE LAW OF CORPORATE OFFICERS AND DIRECTORS* § 6:4 (2006).

2. See *Intermarque Automotive Products, Inc. v. Feldman*, 21 S.W.3d 544 (Tex. App. Texarkana 2000).

3. See Joseph W. Bishop, Jr. *New Cure for an Old Ailment: Insurance Against Directors' and Officers' Liability*, 22 BUS. LAW. 92 (1966).

4. Although the first D & O policy was issued in the 1930s in the U.S. by Lloyd's underwriters. IAN YOUNGMAN, *DIRECTORS' AND OFFICERS' LIABILITY INSURANCE* 144 (2d ed. 1999). The insurance was a response to the wave of lawsuits following the 1929 stock market crash. *Id.*

Starting in the 1960s, D & O insurance was created to protect directors and officers from derivative lawsuits. In general, public policy did not allow for indemnification.⁵ By the 1970s, as the line of insurance continued to grow, coverage was readily available at relatively low cost, despite it being an otherwise unfriendly time for most lines of insurance.⁶ However, the 1980s marked a time of significant change. A major Delaware Supreme Court case is often regarded as the beginning of a new era of shareholder litigation and thus executive liability.⁷ Here, the court found the directors of a corporation personally liable for failing to make an informed business decision with respect to a recent merger.⁸ This was despite the absence of fraud or bad faith.⁹ On the tail of this decision, many other lawsuits increasingly revealed the substantial risks to which corporate officers were being exposed.¹⁰ Also just making this revelation was the D & O insurance market, which subsequently began to harden. Policy limits decreased, premiums increased and the list of exclusions in the policies multiplied considerably.¹¹ By 1987 states began to reduce the potential exposure of Directors and Officers through legislation.¹²

Again the market softened and became more accommodating to corporations. However, a significant underwriting cycle was developing.¹³ The market during 1990s was initially soft, but by the close of the decade began to harden appreciably.¹⁴ This problem persisted into the current decade.¹⁵ Following such large profile scandals such as Enron, Adelphia

5. *Id.*

6. *Id.*

7. Smith v. Van Gorkom, 488 A.2d 858, 46 A.L.R.4th 821 (Del. 1985).

8. *Id.* at 864.

9. Under the business judgment rule, poor decision making is not defense. *Id.* at 872. As the court stated, "fulfillment of the fiduciary function requires more than the mere absence of bad faith or fraud. Representation of the financial interests of others imposes on a director an affirmative duty to protect those interests and to proceed with a critical eye in assessing information of the type and under circumstance [in the case.]" *Id.*

10. See LAW OF CORPORATE OFFICERS AND DIRECTORS: INDEMNIFICATION AND INSURANCE § 8:1.

11. *Id.* For a detailed discussion of the crisis in the market in the late 80s, see Roberta Romano, *What Went Wrong With Directors' and Officers Liability Insurance?*, 14 DEL. J. CORP. L. 1 (1989).

12. See *Id.* §§ 7:22 *et seq.*

13. This underwriting cycle, including its potential causes and effects, will bear significantly upon the topic in this paper. It will be discussed in greater detail *infra*.

14. See Tillinghast Towers Perrin, 2005 DIRECTORS AND OFFICERS LIABILITY SURVEY [Hereinafter Tillinghast 2005 Survey].

15. Though there was a slight softening of the market around the turn of the century. See Tillinghast 2005 Survey.

and Tyco, the D & O insurance market paid out roughly twice as much as it brought in from premiums.¹⁶ The majority of these losses came from shareholder litigation.¹⁷ In 2002 alone, premiums were estimated to have increased anywhere from 25% to 400%, with the largest increases going to the more financially unstable companies.¹⁸ This trend continued into the next year.¹⁹ 2003 was the zenith, however.²⁰ In 2004 and 2005, premiums dropped significantly, returning to lows not seen since 2001.²¹ At the same time, for-profit corporations saw their average limits increase 9% in 2005 alone.²²

These results are somewhat troubling, however. Despite lower premiums²³, higher limits²⁴ and less restrictive policies, claims experience in 2005 was more severe.²⁵ This is attributable to both higher frequency and greater severity in individual claims.²⁶ In addition to this, legal costs have also increased by as much as 100% from 2004 alone.²⁷ Whether this counterintuitive behavior is attributable to underwriting lagging market

16. *Id.*

17. Tillinghast 2005 Survey at 4 (reporting that responding companies experienced 57% of their D & O claims from shareholders).

18. *Id.*

19. *Id.*

20. *Id.*

21. Tillinghast 2005 Survey at 61.

22. *Id.*

23. Tillinghast 2005 Survey at 61 (“reporting that average premium for all participants were approximately 13% lower in 2005 than in 2006”).

24. Although it should be noted that average limits actually decreased for those corporations with assets greater than \$5 billion. Tillinghast 2005 Survey at 24. Also, the most significant increase occurred with the excess layers. There was little change in the limits of the primary layers. This is particularly surprising, given that the average claim is increasingly more expensive and in any event the average is higher than the average primary layer. Staid primary limits indicates greater excess layer exposure, which would imply lower excess layer limits or higher premiums, but the opposite occurred.

25. *Id.*

26. Severity can be measured in several ways, but a common one is average settlement amounts. See Ronald I. Miller, et al., *Recent Trends in Shareholder Class Action Litigation: Beyond the Mega-Settlements, is Stabilization Ahead?* (NERA Economic Consulting, April 2006). In 2005, settlements averaged over \$24 million. *Id.* at 5. This was an increase of over 26% from 2004. *Id.* In fact, the average settlement from '02 to '05 was 67.7% greater than the average settlement value for the years '96 to '01. *Id.*

27. Tillinghast 2005 Survey at 112 (Average expense cost in 2005 was \$781,000 per claim, up from \$370,000 per claim in 2004).

forces or is the result of optimism or increased competition will be addressed below.²⁸

The rising and falling of premiums and limits only tell part of the D & O insurance story. In 2002, Congress passed the Sarbanes-Oxley act in response to the highly publicized corporate scandals discussed above.²⁹ As a consequence, the cost of doing business for publicly-traded companies increased by 90.4%.³⁰ Furthermore, while asset size was the single largest determinant of premium level historically, industry and claims history now play a more significant role.³¹ Thus, large companies with negative claims histories are finding premiums increasingly more painful to pay.³² In fact, 24% of respondents who did not purchase the insurance claimed they declined to do so because the cost was too high.³³

Other legal concerns inform D & O insurance. In particular, most shareholder claims allege a violation of directors' fiduciary duties³⁴ or are securities-based lawsuits.³⁵ Nor are these complaints repetitiously alleging

28. "We attribute this shift to the greater market capacity of the D & O insurance market. However, it will be difficult to sustain this trend, and we expect capacity to begin to shrink. This shrinkage will likely come not from companies exiting the market altogether, but from a reduction in the overall amount of D & O coverage they underwrite." Tillinghast 2005 Survey at 3.

29. Pub. L. No. 107-204, 116 Stat. 745 (2002).

30. This increase was the result of increased accounting fees, compliance rules, rising premiums for D & O insurance, increased director compensation, legal fees and auditor fees.

31. Joseph Warren Bishop, *THE LAW OF CORPORATE OFFICERS AND DIRECTORS* § 8.02 (2006). How much this affects corporate conduct will be discussed in Part II, *infra*.

32. At present no one is finding it difficult to find coverage, however. Tillinghast 2005 Survey ("[A]ll U.S. and Canadian participants reported that they were able to obtain D & O coverage"). This indicates that insurers are still more than willing to underwrite a corporation regardless of the level of risk presented. This is troubling, insofar as underwriters are tasked with risk *selection* as well as risk pricing. There may be a time in the future when the market hardens appreciably that insurance will no longer be offered to the highest risk tier, whatever that may be determined to be. Despite this, the fact that there *are* periods where the vast majority of companies can find coverage testifies to the degree of endogenous risk in the line.

33. Tillinghast 2005 Survey at 21. However, those who gave this reason were only from two of the 6 principal business classes, Durable Goods and Nonbanking Financial Services. *Id.*

34. See Robert B. Thompson & Randall S. Thomson, *The New Look of Shareholder Litigation: Acquisition-Oriented Class Actions*, 57 VAND. L. REV. 133 (2004).

35. These lawsuits are based upon both the Securities Act of 1933 and the Securities Exchange Act of 1934. 15 USCA §§ 77a-77aa (1997 and Sup 2005); 15 USCA §§ 78a-78mm (1997 and Sup 2005).

the same violations.³⁶ And shareholders are not the sole moving party in these lawsuits. The SEC additionally is empowered to bring lawsuits against corporations suspected of securities violations.³⁷ Most violations, however, are alleged to be caused by misrepresentations that adversely affected shareholders.³⁸ The mechanism whereby this impacts the shareholders is stock price.³⁹ These lawsuits typically rely upon a violation of Rule 10b-5 of the Exchange Act.⁴⁰

A. D & O INSURANCE POLICIES AND COVERAGE

The line of Directors' and Officers' Insurance can be divided into three distinct types of coverage: Side A, B and C. Side A coverage is individual coverage that is meant to indemnify corporate officers for any sums for which they become liable to pay.⁴¹ There is often language in the policy that restricts this indemnification to circumstances where the firm is not permitted to indemnify the officer directly.⁴² Side B coverage "reimburses the corporation for its indemnification payments to officers and directors."⁴³ And finally, the least common type of D & O insurance. Side C "protects the corporation from the risk of shareholder litigation to which

36. See William E. Knepper & Dan A. Baily, LIABILITY OF CORPORATE OFFICERS AND DIRECTORS § 17.02 (7th ed. 2003) (containing a list of 170 different bases for corporate liability in shareholder actions).

37. See generally, 15 U.S.C. § 77s; § 77t; § 78u(a); § 78u(d).

38. "Misstatements designed to keep the firm afloat, as opposed to those designed merely to pad executive pay packages, because they arguably benefit the firm may not seem to arise out of agency costs. However, any benefit to current shareholders – through, for example, overstated earnings – comes at the expense of future shareholders – those who buy in under the misrepresentation and therefore pay too much for their shares and also those who fail to sell prior to the corrective disclosure. This reveals a temporal conflict between investors generally." Tom Baker & Sean Griffith, *Predicting Corporate Governance Risk: Evidence from the Directors' & Officers' Liability Insurance Market*, 74 CHICAGO L. REV. 487, 497 fn 38, citing Steven L. Schwartz, *Temporal Perspectives: Resolving the Conflict Between Current and Future Investors*, 89 MINN. L. REV. 1044 (2005). For a detailed discussion of why corporations are willing to mislead corporate investors, see Donald C. Langevoort, *Organized Illusions: A Behavioral Theory of Why Corporations Mislead Stock Market Investors*, in BEHAVIORAL LAW AND ECONOMICS (Cass R. Sunstein ed. 2000).

39. See Generally, Robert B. Thompson & Hillary A. Sale, *Securities Fraud as Corporate Governance: Reflections Upon Federalism*, 56 VAND. L. REV. 859, 903 (2003).

40. 15 U.S.C. § 771 (2000); C.F.R. § 240.10b-5 (1995).

41. Baker, et al, *Predicting Governance Risk*, supra note 38, at 499.

42. See *Id.* at 499, note 51.

43. *Id.* at 499.

the corporate entity is itself a party.”⁴⁴ Side A and B coverage is generally referred to as “standard coverage.”⁴⁵

While the mechanics of each type of policy are different, so is the general liability structure and degree of protection. For example, Side A insurance frequently does not have any deductible associated with the coverage.⁴⁶ Side B and C, however generally have large retentions.⁴⁷ Some companies now purchase split retentions, where the deductible is higher for securities claims.⁴⁸

D & O insurance policies typically cover settlement amounts, legal fees and compensatory damages.⁴⁹ This coverage is contingent upon the liability coming from the conduct of directors and officers in their professional capacity.⁵⁰ The policies also have three distinct exclusions. The first exclusion removes coverage from claims involving “actual fraud.”⁵¹ Secondly, there is no coverage for acts that were committed prior to the start of the policy.⁵² This is called the “prior acts” exclusion.⁵³ Finally, because some acts may result in the Corporation suing its own directors or officers, there is the “Insured v. Insured” exclusion.⁵⁴ This exclusion removes coverage for expenses arising out of litigation between named insureds on the policy.⁵⁵ Myriad other exclusions exist,⁵⁶ but since

44. *Id.* “The Insurer will pay on behalf of the Company Loss which the Company shall become legally obligated to pay as the result of a Securities Claim...against the Company for a Wrongful Act...” *Id.* at note 53, citing *Hartford Specimen Policy*, §I.C.

45. Tillinghast 2005 Survey at 47.

46. Tillinghast 2005 Survey at 53 (98% of U.S. respondents with Side A coverage had no deductibles).

47. Deductibles are averaged by asset size. For firms with assets up to \$400 million, the average retention or deductible in 2005 was \$212,491. Firms with assets from \$400 million to \$1 billion saw an average that was \$812, 500; between \$1 and \$2 billion: \$1,217,000; between \$2 and \$5 billion, \$3,327,966 and for firms with assets over \$5 billion, the average retention was \$6537,143. *Id.* at 52, tbl 38.

48. *Id.* at 53 (reporting that 4% of U.S. respondents and 57% of Canadian respondents had this type of split retention). What is the cause of the marked difference between U.S. and Canadian firms is not explained.

49. *Hartford Specimen Policy* § IV.J.

50. *Id.*

51. *Chubb Specimen Policy* §§ 7-8.

52. *See, e.g., AIG Specimen Policy* §§ 4.h., 1.

53. *Id.*

54. *Id.* at §§ 4.i., j.

55. *Id.*

56. *See generally, Id.* § 4 for list of these exclusions. The most common types of exclusions are: illegal profit or gains, dishonesty or fraud, questionable payments, inadequate insurance, product defects, injury, sickness and damage, damage to property,

these contracts are negotiated by the insurer and insured, they are highly individualized and characterizing them with broad strokes would give a false sense of the industry uniformity. Suffice it to say that potential insureds are concerned with shareholder litigation risk primarily and the policies will generally reflect that concern.⁵⁷

It should also be noted that each corporation does not have one D & O insurance policy from one insurer. In fact, corporate insureds frequently possess many layers of insurance from several insurance companies.⁵⁸ These layers can be broadly termed primary or excess.⁵⁹ Excess insurance generally exists simply because insurers are unwilling to underwrite the whole risk for a single large firm.⁶⁰ To do so would place too much correlated risk in the insurer's portfolio, with potentially catastrophic consequences.⁶¹ There is qualitative evidence which indicates that \$50

guarantee or warranty, copyright, professional indemnity/liability, pensions, fines, failure to control pollution, known actions, deliberate acts. IAN YOUNGMAN, *DIRECTORS' AND OFFICERS' LIABILITY INSURANCE* at 37-39.

57. The following is a partial list of risks for which firms would be concerned: employment, unfair practices, abuse of authority, wrongful dismissal, libel and slander, non-payment or underpayment, misrepresentation, takeovers and mergers, wrongful trading, financial, contractual, personal (conspiracy or bribery), the state (for price-fixing or sundry under illegal acts), company regulations, mismanagement, intellectual property and corporate manslaughter. IAN YOUNGMAN, *DIRECTORS' AND OFFICERS' LIABILITY INSURANCE* at 12-16. Corporations would like protection from as many of these as possible, but frequently will likely be able to receive cover on all of them.

58. Outside D & O insurance, it has not been unusual historically for one company to have dozens of insurers covering different parts of the same risk. This is quite common with CGL policies, the impact of which is best seen in the asbestos litigation in the last 30 years.

59. This, of course, ignores reinsurance, whether standard or retrocessionary. Although, non-treaty insurance can often look like excess-of-loss coverage, it need not and may look more like a vertical slice than the horizontal partitioning of the risk that defines traditional excess coverage.

60. Insurers, like investors, generally wish to diversify their portfolio. Since all insurers have finite resources, having a large part of their risk placed on one insured could lead to a devastating loss and possible bankruptcy. As some corporations have upwards of \$300 million in policy limits across all of their layers, potential exposure is considerable to any undiversified insurer.

61. Offering a single insured too much insurance coverage is an easy example of excessive correlated risk. However, it can pop up in other settings and natural disasters have been the historical culprit. Both the San Francisco and Chicago fires are examples of disasters that bankrupted many local insurers precisely because their risks were geographically highly correlated.

million dollars is the largest single insurer limit currently available.⁶² In order to achieve the desired coverage, several policies must be purchased. The aggregation of the multiple policies is generally referred to as “towers of insurance.”⁶³ The first layer of insurance, the one that would respond first to a lawsuit, is called the primary layer.⁶⁴ All layers stacked on top of the primary layer are referred to as “excess layers.” These excess layers could be vertical layers or horizontal layers. The more common excess layer is the horizontal one, which means that the excess insurer would pay the first \$X excess of the primary layer, after which it will have exhausted its liability. The vertical layer can be seen as a proportional layer of insurance that pays a percentage of several excess layers. So if two excess insurers each had \$5 million in excess coverage, one on top of the other, for a total of \$10 million of coverage above the primary layer, another insurer could agree to pay for 20% of both layers. Thus, each excess insurer’s total liability risk is reduced to \$4 million. In this way, the proportional insurer could be seen as a type of reinsurer of the two excess insurers.

The dynamics of this is important, because insureds want some degree of consistency with the policy. This is generally referred to as “concurrency.”⁶⁵ This is where the higher layer policies “follow the form” of the underlying policy.⁶⁶ What this generally means in practice is that most definitions are omitted from the excess insurance policies, except to say that they take all the definitions, exclusions, etc from the underlying policy.⁶⁷ The law surrounding these “follow the forms” clauses is little, but in recent years, considerable excess insurance and reinsurance losses in areas like asbestos has substantially increased the number of cases that discuss this historically esoteric area.⁶⁸

62. Tom Baker, *Predicting Corporate Governance*, *supra* note 38, at 20. In fact, as of late 2005, no one insurer was willing to offer a policy larger than \$25 million.

63. *Id.*

64. The market for primary insurance is dominated by two firms: AIG and Chubb, which combine to control 53% of the market by premium volume. Tillinghast 2005 Survey at 86. However, this share decreases to only 36% of total policy count. *Id.*

65. See Barry R. Ostrager & Mary Kay Vyskocil, *MODERN REINSURANCE LAW AND PRACTICE* §2.03[a] (2d ed. 2000). To see how courts have interpreted this clause, see *North River Ins. Co.v. CIGNA Reins. Corp.*, 52 F.3d 1194 (3d Cir. 1995);

66. See Ostrager, *supra* note 65 at § 2.03[a].

67. *Id.*

68. See *Sumitomo Marine & Fire Ins. Co. v. Cologne Reins. Co.*, 75 N.Y.2d295, 298, 552 N.E.2d 139, 140 (1990) (“reinsurance is an area of law “in which differences [were] often...settled by handshakes and umpires, and pertinent precedents [were] few in number]. See also Ostrager, *supra* note 65 at 1-3 (“The proliferation of reinsurance disputes, generated in large part by pollution and asbestos claims and insurer and reinsurer

Because of the nature of D & O insurance layers, the premiums paid in exchange for the higher layers are lower per dollar than the premium for the primary layer.⁶⁹ This makes sense, since the further a coverage layer is from the base, the less likely any one claim or group of claims will exhaust all of the underlying layers. Thus, when one speaks of the premium paid for a firm's D & O coverage, the number provided is actually a combination of the premiums paid to several insurers.

B. THE INSURANCE UNDERWRITING CYCLE

An "underwriting cycle" can be described as the following:

Profits in property and liability insurance have tended to rise and fall in fairly regular patterns lasting between five and seven years from peak to peak; this phenomenon is termed the underwriting cycle. Stages of the underwriting cycle may be described as follows: initially, when profits are relatively high, some insurers, wishing to expand sales, start to lower prices and become more lenient in underwriting. This leads to greater underwriting losses. Rising losses and falling prices cause profits to suffer. In the second stage of the cycle, insurers attempt to restore profits by increasing rates and restricting underwriting, offering coverage only to the safest risks. These restrictions may be so severe that insurance in some lines becomes unavailable to the marketplace. Insurers are able to offset a portion of their underwriting losses through earnings on investments. Eventually the increased rates and reduced underwriting losses restore profits. At this point, the underwriting cycle repeats itself.⁷⁰

This underwriting cycle also does not generally coincide with the more well-known business cycle.⁷¹ There is a fair amount of uncertainty as to

insolvencies, has spurred reinsureds and reinsurers to resort to litigation and arbitration with much greater frequency").

69. See Tom Baker, et al, *Predicting Governance Risk*, *supra* note 38, at 20-21.

70. *Insurance*, in *ENCYCLOPAEDIA BRITANNICA*, available at <http://www.britannica.com/eb/article-13260> (September 18, 2008).

71. Barbara D. Stewart, *Profit Cycles in Property-Liability Insurance*, in 1 *ISSUES IN INSURANCE* 294, 294-295 (John D. Long & Everett D. Randall eds., Am. Inst. For Prop. & Liab. Underwriters 1984).

exactly what causes these cycles to persist, but a standard explanation has been provided for years. This explanation is largely driven by economics.

The standard explanation relies upon three unique insurance economic characteristics. The first is that the traditional economic balancing of supply and demand cannot be achieved in the insurance industry because the demand, i.e. the number of claims and their respective costs, cannot be accurately determined *ex ante*.⁷² The next problem originates from the unique nature of the insurance industry. Profitability is not limited to bringing in more premium income than payments made under the policies, but also from investment income. These investments are sensitive to the standard variables of investment theory, particularly interest rate.⁷³ If the interest decreases, insurer reserves will be underfunded and additional income is required. This can only be acquired from higher underwriting profitability.⁷⁴ Finally, it has been argued that reinsurance capacity undermines the underlying insurance market whenever the capacity decreases.⁷⁵ When this occurs, insurers lose an important means of risk reduction.⁷⁶

72. Robert F. Wolf, *Actuary Counters Hunter on Med Mal Insurance Crisis*, NAT'L UNDERWRITER 10 (Nov. 11, 2002).

73. This is due to the required conservative investment strategies insurance companies must make in order to guarantee reserves are available to pay claims. See Joseph D. Haley, *A Cointegration Analysis of the Relationship between Underwriting Margins and Interest Rates: 1930-1989*, 60 J. RISK AND INSURANCE 480, 486-487 (1993). For a mathematical justification of the prior article's methodology, see Scott E. Harrington & Tong Yu, *Do Property-Casualty Insurance Underwriting Margins Have Unit Roots?*, 70 J. RISK AND INSURANCE 715 (1997). This asset-liability matching is so important that actuaries must learn the basics of it early in their examination process. See generally The Society of Actuaries, available at www.soa.org. This idea finds further quantitative traction in the degree of importance rho matching plays in risk hedging at insurance companies. Rho is defined as the change in the value of an underlying asset or liability due to a change in the interest rate. Being under- or over-hedged can significantly expose an insurance company to market risk, thereby causing substantial modifications in reserving needs. Typically rho can be hedged by purchasing long or short positions in swaps.

74. For a discussion of this in the medical malpractice field, see Tom Baker, *The Medical Malpractice Underwriting Cycle*.

75. Roberta Romano, *What Went Wrong with Directors' and Officers' Liability Insurance?*, 14 DEL. J. CORP. L. 1, 18-19 (1989).

76. *Id.* See also Ostrager, *supra* note 65 at § 1.02[b] ("By ceding portions of their risk to reinsurers, insurers are able to assume more risk than would otherwise be possible"). The basis for this is more than just unloading some risk:

[I]nsurance companies must meet certain financial standards in order to do business. The insurer must maintain specified minimum reserve requirements based on the amount and type of reinsurance in force and the insurer's loss exposure. The reserve requirements

The pricing problem seems to be the most significant driver of these underwriting cycles, giving rise to what is known as “the Winner’s Curse.”⁷⁷ While analyses of the Winners’ Curse are often restricted to auction situations, there is an easy analog to the insurance market.⁷⁸ Studies done have shown that two principle risks affect the frequency and severity of the Winners’ Curse.⁷⁹ The first is “the degree of uncertainty concerning the value of the item for bid.”⁸⁰ The second is “the number of competing bidders.”⁸¹ The larger the number for either, the greater the risk of suffering from the Winner’s Curse.⁸²

The problem with this analysis, though accurate at describing the variables and mechanisms of the underwriting cycle, is that it does not address the “how.” This has been well articulated in the following way (though with respect to the medical malpractice underwriting cycle):

establish the assets that an insurer must have available to pay all claims, losses, and adjustments and settlement expenses. These requirements have the express purpose of adequately protecting the insured and securing the solvency of the insurer. A contract of reinsurance is one by which an insurer procures a third person to insure him against loss or liability by reason of such original insurance. A fundamental purpose of reinsurance is to permit an insurer to reduce its reserve requirement. California requires insurers to file financial statements with the state. On those statements, an insurer may deduct certain risks from its liabilities, provided those risks are subject to reinsurance. By utilizing reinsurance, therefore, an insurer can spread the risk its undertakes over a larger number of policies, effectively reduce the amount of reserves required to maintain its business, and increase its profitability.

American Re-Insurance Co. v. Insurance Commission, 527 F. Supp. 444, 452-53 (C.D.Cal. 1981).

77. The Winner’s Curse “occurs in competitive situations when a successful buyer finds that he or she has paid too much for a commodity of uncertain value.” Max H. Bazerman and William F. Samuelson, *I Won the Auction But Don’t Want the Prize*, 27 J. CONFLICT RESOLUTION 618, 618 (1983). See also, Richard H. Thaler, *Anomalies: The Winner’s Curse*, 2 J. ECON. PERSPECTIVES 191 (1988); Jeremy Bulow & Paul Klemperer, *Prices and the Winner’s Curse*, RAND JOURNAL OF ECONOMICS (2002).

78. The insurance market, especially D & O insurance, is very much like an auction, with many bidders – the insurers – bidding for something of value – the insurance premium – the value of which is uncertain at the time of purchase and only becomes certain at a much later time. As Sean M. Fitzpatrick wrote, “the insurance market...is a particularly fertile ground for instances of the Winner’s Curse.” Sean M. Fitzpatrick, *Fear is the Key: A Behavior Guide to Underwriting Cycles*, 10 Conn. Ins. L. J. 255, 260 (2002-2003).

79. Bazerman & Samuelson, *supra* note 77 at 1.

80. *Id.*

81. *Id.*

82. *Id.*

But [this analysis], like the economists and industry observers who preceded them, concentrated on the “proximate” causes of the medical malpractice crisis, without delving more deeply to discover what might be called the “ultimate” causes. Put another way, the GAO study accurately reported *what* had occurred in the medical malpractice market and described the mechanics of *how* it had occurred, without finally addressing the more fundamental question: *why?*⁸³

This approach is the behavioral approach to the underwriting cycle.⁸⁴ The purpose of elaborating on these root causes is integral to thesis of this paper: that the underwriting cycle is explainable by behavioral factors and the heuristics of underwritings. Especially in low frequency, large loss areas of insurance, like D & O or catastrophic risk insurance, where the dynamics leading to losses are many and fluid, these factors further exacerbate the cycle and destabilize the market sufficiently that profitability will always be difficult to achieve, or will be achieved with a dangerous amount of loss potential.⁸⁵ However, before this can be fully

83. Sean M. Fitzpatrick, *Fear is the Key: A Behavior Guide to Underwriting Cycles*, 10 CONN. INS. L. J. 255, 263 (2002-2003).

84. *Id.* at 264. The problem of applying traditional economic principles to insurance has long been questioned. The following excerpt articulates the point well:

[F]ew firms are able to determine their marginal revenue or cost curves. To provide a profit, they rely on marking up the average cost per unit by some given percentage. While prices may be allowed to decline below average costs, prices will not be set below variable cost. Insurers tend to follow the same pricing method but, in addition, must contend with the following problems.

1) Average costs in insurance are predominately variable in nature and to a large extent beyond the control of the insurer.

2) Accurate projections of average costs, particularly claims items, require sufficient numbers of exposures to allow the ‘law of large numbers’ to operate.

3) Prices may violate the economic rule and be set below unit variable cost, if losses and claims expenses are far in excess of those projected by the actuaries.

4) For many insurers, within the constraints of capacity, unit cost does not change significantly with sales.

D.E. Ayling, *infra* note 91, at 24 (internal citation omitted).

85. This should not be taken to mean that Catastrophic Risk Insurance lacks viability. In fact, engineering science has long utilized some tools for the situation in which there is very little data. In particular, the Weibull Distribution is most effective when modeling

evaluated, a more detailed discussion of underwriting in practice must be done. Then we can discuss what this means for the D & O Insurance market.

C. UNDERWRITING PRACTICES

In Part II, this paper will diffuse some of the public policy bases behind firm-by-firm underwriting of D & O insurance, but there yet may be an adequate *economic* basis for individualized ratemaking. After all, if insurance companies can successfully distinguish good risks from bad during the underwriting process, then they would have a strong incentive to do so. If an insurance company's risk portfolio contains a higher proportion of good risks than its competitors, it will have more profitable claims experience. Greater profitability in turn would allow the insurer to be more aggressive in attracting other clients. Thus, market share would be increased. This section will attempt to cast doubt on underwriters' ability to do that.⁸⁶

Underwriting "is the process of accepting or rejecting risks."⁸⁷ Underwritings focus on four general areas in assessing risks: the premium rate, the policy provisions, the hazard, and reinsurance arrangements.⁸⁸ Depending on the quality of risk, the underwriter has many different discretionary steps that can raise or lower the insurer's exposure to that

phenomena for which little or no data is actually available. The problem, however, is that for the modeling to be of any value, the mode of failure must be singular and quantifiable, something often missing in the D & O market. That, combined with the more ethereal underwriting practices, militates against this methodology.

86. This in no way contradicts the analysis in the next section, for there we are concerned with the market for D & O insurance in its entirety. Here, we are focusing on the economic behavior of a single firm. A firm that rates better than its competitors will have a competitive advantage, offering good risks lower rates. If the insurer was equally good at pricing bad risks, they would not offer insurance at actuarially unsound premiums. Other insurers, possessing less discerning underwriting practices, may undercut the more accurate competitor, yielding the result that insureds may still have little incentive to change their governance practices. In any event, this discussion rests entirely upon the assumption that a particular insurer or subgroup of insurers possess unique underwriting prowess, the likelihood of which is at best questionable.

87. ROBERT B. HOLTOM, UNDERWRITING PRINCIPLES AND PRACTICES 11 (1973). "[It] is a systematic technique for evaluating risks which are offered by prospective insureds. The function of underwriting involves evaluating, selecting, classifying and rating each risk, and establishing the standards of coverage and amount of protection to be offered to each acceptable risk." *Id.*

88. George L. Head, *Underwriting in Five Easy Lessons?*, 35 J. RISK AND INS. 307, 308 (1968).

risk.⁸⁹ However, experience is frequently mentioned as a key component is successful underwriting.⁹⁰ That is why rating decisions are frequently made by the lead underwriter.⁹¹ After the initial rating decisions are made, more junior underwriters follow the guidelines the lead underwriter made.⁹²

In many traditional lines of insurance, both experience and scope of the line has created many mathematical models that allow underwriters to expeditiously price risks.⁹³ However, such is not generally the case for D & O underwriters.⁹⁴ Though, again, generalizations should be done carefully here, because the market for D & O is relatively young and various underwriting methods have been utilized by different insurers.

The D & O underwriting initially focuses on three risks.⁹⁵ The first part focuses on the individual application of the insured, which contains a questionnaire.⁹⁶ The second part involves an independent investigation of all publicly available data.⁹⁷ And finally, the application process finishes with acquiring as much private information about the firm as possible.⁹⁸

Again how this data is utilized is varied, but the following quote demonstrates the more informal nature of D & O underwriting:

89. *Id.*

90. *Id.* See also Tom Baker, et al, *Predicting Governance Risk*, *supra* note 38, at 24, note 101 (“We literally sat at a round table and just based upon the experience of the more senior folks, we would say that this is a great number, and we just threw a number out of the hat,” *citing* Underwriter #6).

91. D.E. Ayling, *UNDERWRITING DECISIONS UNDER UNCERTAINTY: THE CATASTROPHE MARKET*, 19 (1984).

92. *Id.*

93. See Neal Gendler, *Rise in Automated Underwriting Spurs Credit Scoring Use; Computer Doesn’t Decide to Grant Loan, but Whether Secondary Loan Standards Are Met*, *Star Tribune* (Minneapolis, MN January 2, 1999). See also Tom Baker, et al, *Predicting Governance Risk* at 24, note 101.

94. See note 75, *supra*.

95. Baker, *supra* note 38, at 510.

96. *Id.* (this “includ[es] the experience of covered officers and directors and the claims history of the corporation, plans for acquisitions or securities issuances, and whether any prospective insured has “prior knowledge” of acts or omissions likely to give risk to a claim.”)

97. *Id.* at 511 (“They use a wide variety of publicly available data sources including SEC filings, Bloomberg reports, analyst ratings, corporate governance reviews from specialized providers such as Corporate Library, and...forensic accounting.”)

98. *Id.* (This is accomplished “through a series of meetings with the prospective insured’s senior managers – often the Chief Financial Officer or Treasurer as well as members of the accounting and legal departments and occasionally...the [CEO]”).

“We look at the industry that the company operates in, trying to figure out if we are in a mature industry, a growth industry, a start up section of the industry, whatever. Are we working with proven technology, new technology, proven consumer goods, new consumer goods?

We look at the history of the company and see if M&A is a prominent part of their planning process for the future or not. We look if there are takeover risks. We look if there is a restructuring perhaps necessary in the future of the company. We examine the type of securities filings they did at the SEC... We look at any SPEs, SPVs, joint ventures that they are using to grow strategically.

Then we dive into the corporate governance. We examine who the directors and officers are, their applicable experience. We look at interlocking board relationships. We actually keep a separate database here. Since 1996 we can run our database and tell you if any one director or officer was a defendant in a securities class action or derivative action...[W]e record which company they were serving in when they were sued, but what we can then do is go back and look to see if the folks that we are underwriting now were sued in what was a fender bender or if it was a complete corporate meltdown...So we have a driving record in this.

We look at the organization of the corporate governance committees and independence of those committees and how active they are and then we look at insider ownership [and] compensation packages. Then we move into a broader understanding of the entire ownership of the company...and what conflicts may or may not exist within ownership interests.

We take a serious look at the equity trend of the company over recent years and what made its price earnings multiple what it is. We examine insider trades. We look at any intellectual property that the company may be relying upon. We look at the regulatory structure and who the regulators may be and what the history with the regulatory relationships were. We look at both former existing director and officer litigation as well as general litigation that the corporation may be involved in that could be a threat to the future value of the company. We

look at how they handle corporate investor communications. We look at how they are handling legislative or environmental issues that may face the company. We look at how they may handle employment practices and bankruptcy of course. We have an entire dedicated review of the bankruptcy and potential emergency or liquidation.

Then we go into a very meticulous breakdown of the financials of both the balance sheet and the cash flow statement and the profit and loss statement. You know, your typical ratio analysis is supported by about 55 or so different ratios. Underneath those ratios we look meticulously at who the auditors are, what the revenue recognition policies are, how they manage accounts receivable, inventory, payables, valuing intangibles, you know, formulating debt and appreciation, capital expenditures, pension obligations, and we look even at vendor financing if it exists. We summarize, you know, what makes us want to write the account and what makes the necessity of the insurance relevant to the risk of the company. And then we price it.⁹⁹

Thus, while a substantial amount of data is analyzed, it is frequently driven more by intuition than by an automated or computerized underwriting scheme.

D. BEHAVIORAL ECONOMICS AND UNDERWRITING

Behavioral Economics attempts to reunify psychology and economics. In other words, replace the utility maximizing *homo economicus* with a more empirically supportable version.¹⁰⁰ Perhaps most important to underwriting is Prospect Theory. This adjustment to the traditional Utility Theory stipulates that people use past experience to weight the likelihood

99. *Id.* at 512-514.

100. More specifically, behavioral economics seeks to displace the following four principles: Expected Utility, Equilibrium, Discounted Utility and Own-Payoff Maximization. The Behavioral Economic substitutes are Prospect Theory, Learning, Hyperbolic Discounting and Social Utility, respectively. Colin Camerer, 96 *Proceedings of the National Academy of Sciences of the United States of America* 10575, 10576 (1999).

of future outcomes.¹⁰¹ While this theory is about how individuals attempt to maximize wealth¹⁰², its portability to underwriting is not that much of a stretch and has important implications. For example, if past experience informs underwriting judgments for D & O underwriter's risk selections and the efficacy of those past decisions in the present corporate climate is questionable, then it is likely that the resulting judgment will not be wealth maximizing for the insurance company.

Underwriters are typically concerned with two things: "The desire for financial reward" and "the fear of losing one's job."¹⁰³ The payment structure for underwriters is tied precisely to these two variables. Insurers typically pay underwriters based upon how much insurance they write, not on the long term profitability of that insurance. And even in the presence of long term incentives, the average underwriter is going to pursue those actions that are more likely to create immediate or near immediate gain.¹⁰⁴ This can be partly explained by the dominant evaluation schemes, such as annual bonuses, reviews and promotions. This can be further exacerbating by the turnover rate among corporations in general. If an underwriter does well this year, then they can jump ship to another insurance company before the full effects of his or her underwriting decisions are felt.¹⁰⁵

101. *Id.*

102. *Id.*

103. Sean M. Fitzpatrick, *Fear is the Key: A Behavioral Guide to Underwriting Cycles*, 10 CONN. INS. L. J. 255, 264 (2003-2004).

104. *Id.* at 265. This is also consistent with the hyperbolic discounting supposed under behavioral economics which strongly discounts the value of near future benefits in favor of more immediate gain or very long term gains. See Peter D. Sozou, *On Hyperbolic Discounting and Uncertain Hazard Rates*, 265 PROCEEDINGS: BIOLOGICAL SCIENCES 2015, 2016-2017 (1998) ("arguing that experimental subjects preferences did not match exponential discounting and that hyperbolic discounting was consistent with subjects having exponential prior distributions with bayesian updating of an unknown hazard rate.").

105. Although this may not be likely. A metastudy of performance and turnover rates found that high performers were *less* likely to leave their job. Glenn M. McEvoy & Wayne F. Cascio, *Do Good or Poor Performers Leave? A Meta-Analysis of the Relationship Between Performance and Turnover*, 30 THE ACAD'Y OF MANAGEMENT J. 744, 750 (1987). However, the study's confidence interval included both zero and positive correlations, so the efficacy of this result is uncertain. The underwriting profession also may have some different characteristics, such as transportability. Compare William Wilt, et al, *Leverage in All The Right Places*, REINSURANCE: GLOBAL INSIGHTS, Oct. 1, 2003 at 8, 16 (noting the ease with which underwriters can change jobs) with John L. Cotton & Jeffry M. Tuttle, *A Meta-Analysis and Review with Implications for Research*, 11 THE ACADEMY OF MANAGEMENT REV. 55, 60 (1986) ("finding that the availability of opportunities elsewhere was positively correlated with job turnover rates").

When profitability is up, relatively easy access to the insurance market causes an increase in the new entrants.¹⁰⁶ New entrants further increase the availability of jobs. This only exacerbates the turnover problem and diminishes the incentives generated by long term benefits.

Finally, the structure of insurance companies power base and interests can sometimes empower the underwriter and sometimes not.¹⁰⁷ When the support is behind underwriters they will generally try to write as much insurance as they can without any one in charge asking too many questions. Also, when corporate pressure to maintain market share increases, underwriters continually become more aggressive with their underwriting. When the market hardens, however, the adjustors' and actuaries' power is on the rise and conservative underwriting practices become the norm.¹⁰⁸

Thus, the structure of insurance companies combined with the extant compensation structures may play a role in the underwriting cycle. But if this is true, it seems that insurance companies are behaving irrationally by maintaining this inefficient organizational scheme.¹⁰⁹ And if they are behaving irrationally, it would seem likely for them to have recognized the problem long ago. The end result is that cycle-mitigating strategies should have already been employed and the underwriting cycle should be less severe.¹¹⁰ The fact that they have not should then be regarded as some evidence that the organizational characteristics of insurance companies is not a significant driver of the underwriting cycle.

But this conclusion is premature. Recent scholarship has become interested in "system justification theory." This theory articulates and evaluates the tendency of individuals in a group to maintain the status

106. See Barbara D. Stewart, *Profit Cycles in Property-Liability Insurance*, in 1 ISSUES IN INSURANCE 288-89 (John D. Long & Everett D. Randall eds., Am. Inst. For Prop. & Liab. Underwriters 1984).

107. See Fitzpatrick, *supra* note 103 at 266.

108. *Id.* at 269.

109. As Fitzpatrick observes, "the single best means of mitigating underwriting cycles would be to tie a more substantial portion of the overall compensation of underwriters, claims analysts, and actuaries – as well as the senior managers of their companies – to profitability achieved over time frames appropriate to their class of business." Fitzpatrick, *supra* note 103 at 274. Based upon empirical support for hyperbolic discounting, this could be achieved with a combination of short-term rewards and very long term rewards, such as increased pension contributions or greater visibility to long-term career prospects. For a discussion of hyperbolic discounting, see note 100 *supra* and accompanying text.

110. Though it will never completely go away, as the unique characteristics of the insurance industry essentially guarantee the perpetuation of the cycle. The use of behavioral economics is to evaluate root causes that can reduce the cycle, not eliminate it.

quo.¹¹¹ This theory “suggests that people are motivated to accept and perpetuate features of existing social arrangements, even if those features were arrived at accidentally, arbitrarily, or unjustly.”¹¹² The diverse application of this theory can be combined with corporate behavioral research. In corporate settings, there is a strong motivation to resist change once a course of action is adopted.¹¹³ Furthermore, individuals who stand to profit because of a prevailing belief that serves their interests further complicates the problem.¹¹⁴

The current corporate culture in the insurance industry manifests these characteristics. There is a strong inertia keeping the current reward structure in place. It is unlikely that this will change immediately. Furthermore, the evidence available is not absolute in the condemnation of the current system. Finally, the other alternatives discussed above are not developed to the extent that they can be tried by an insurance company. Thus the current system will not likely change, even if it appears that a better system is available.

E. HEURISTICS AND UNDERWRITING

A heuristic is a simple rule that helps analyze a large amount of data.¹¹⁵ Underwriting can be compared to “risky choice heuristics.” A risky choice heuristic contains three distinct components: “(1) The alternatives available to the decision maker, (2) Events or contingencies that relate actions to outcomes and (3) The values associated with those outcomes.”¹¹⁶ The risky choice heuristic takes a “problem space” and through a series of rules of thumbs, simplifies that space to a manageable level.¹¹⁷ Researchers have generally studied heuristics through the construction of mathematical

111. See Gary Blasi & John T. Jost, *Symposium on Behavioral Realism: System Justification Theory and Research: Implication for Law, Legal Advocacy and Social Justice*, 94 CAL. L. REV. 1119, 1123 (2006) (“The theory...posits a general human tendency to support and defend the social status quo, broadly defined”).

112. *Id.* at 1124.

113. See Donald C. Langevoort, *Organized Illusions: A Behavioral Theory of Why Corporations Mislead Stock Market Investors (and Cause Other Social Harms)*, in LAW AND BEHAVIORAL ECONOMICS 144, 151 (Cass R. Sustein ed. 2000).

114. *Id.*

115. Don N. Kleinmuntz, *Cognitive Heuristics and Feedback in a Dynamic Decision Environment*, 31 MANAGEMENT SCIENCE 680, 680 (1985).

116. Eric J. Johnson & John W. Payne, *Effort and Accuracy in Choice*, 31 MANAGEMENT SCIENCE 395, 396 (1985).

117. *Id.*

models and computer programs.¹¹⁸ While the conclusions of this research are diverse, several observations are important to the scope of this paper.

First, as the number of potential outcomes increases, the chances that these heuristics work efficiently at arriving at an acceptable outcome generally diminish.¹¹⁹ This is fairly problematic for underwriters, where the number of options available, such as whether to accept or reject the risk, the price and exclusions, is very considerable. The research here would then recommend that the capacity to properly gauge the risk would be improved if the number of available decisions is decreased. This can be accomplished by the method discussed in Section III, *infra*.

Yet another difficulty to be contained is that the studies that show high accuracy with heuristics is that they assume all knowledge about the tasks is complete and accurate.¹²⁰ A relaxation of that assumption can result in wildly different outcomes.¹²¹ In recognition the lack of clear information about outcomes in D & O underwriting, discussed *supra*, this questions whether heuristics can consistently predict the quality of a potential risk.

Finally, increasing the complexity of the heuristic generally leads to, at best, marginally improved results.¹²² The solution, therefore, is not that underwriter's should increase the complexity of their task in an attempt to improve their risk-rating ability, but rather to create a simple basis from which to work. This can be accomplished by automating a reasonable portion of the process. The end result will be a simplified solution space and limited options, both factors which are favorable correlated with efficient heuristics.¹²³

Underwriting is not easy. It is full of compromises and rapid processing of noisy information, the value of which is not always. In D & O insurance, this problem is even more of a threat to the efficacy of an

118. See generally *Id.* See also Klenmuntz, note 115, *supra*; K.D. Glazebrook, et al, *Cost Rate Heuristics For Semi-Markov Decision Processes*, 29 J. OF APPLIED PROBABILITY 633 (1992).

119. See Johnson, et al, note 116, *supra*, at 403 ("Increasing the number of outcomes...does not affect the level of absolute and relative accuracy of the equiprobable heuristic. Other rules, in contrast show decreases in accuracy as the number of outcomes increase"). As the equiprobable heuristic (which implies all outcomes have the same probability, does not accurately represent underwriting, the conclusion above follows.

120. Don N. Kleinmuntz, *Cognitive Heuristics and Feedback in a Dynamic Decision Environment*, 31 MANAGEMENT SCIENCE 680, 697 (1985).

121. *Id.*

122. *Id.* at 696.

123. See generally, Eric J. Johnson & John W. Payne, *Effort and Accuracy in Choice*, 31 MANAGEMENT SCIENCE 395, 402-412 (1985).

underwriter's judgment. The section evaluated the economic basis for individual underwriting. The purpose was to determine whether or not there was substantial value to be added by individualized underwriting of corporations. Through a survey of several different fields of economics, finance and behavioral theory (including heuristics), a strong argument can be made that individual underwriting does not necessarily lead to superior results and in fact may even create greater variability in outcomes.¹²⁴

II. CORPORATE GOVERNANCE AND UNDERWRITING

The purpose of criminal and civil penalties serve two purposes: one *ex ante* and the other *ex post*. The *ex post* goal is to punish those who commit social wrongs. The *ex ante* goal is to deter people from committing those social wrongs. In this way, regulations of the SEC and statutes of the various states and the federal government are meant to either punish or deter directors and officers from committing what is perceived as socially harmful acts. This dynamic, in the case of tortious acts, is upset when insurance comes into play.¹²⁵

Not all is lost, however. Insurers revive the deterrence goals of tort law through a combination of factors. These include the cost and availability of insurance, the exclusions of certain conduct, and the right to recover against insureds in certain circumstances.¹²⁶ There are natural correlates in D & O insurance for these, as well.

In D & O liability insurance, three methods of deterrence are available. The first means by which insurers the objectives of securities laws is by setting the price "based upon the best assessment of the liability risk of each individual corporation..." The second means by monitoring and improving corporate governance. The final method is by controlling the defense and settlement of the claims. The issue of price has already been discussed above and third method is beyond the scope of this paper. The second method, monitoring corporate governance, is the topic of this section. One significant objection to the alternative underwriting method

124. Studies have indicated excess variability in stock prices as the result of irrational expectations. *See generally*, George Bulkley & Richard D. F. Harris, *Irrational Analysts' Expectations as a Cause of Excess Volatility in Stock Prices*, 107 THE ECON. J. 359 (1997).

125. Though not in the case of criminal acts. For policy reasons, intentional harms are not insurable. In D & O insurance this translates to such acts as fraud. *See* note 51 *supra* and accompanying text.

126. For a more detailed discussion of this, see Tom Baker, *Liability Insurance as Tort Regulation: 6 Ways That Liability Insurance Shapes Tort Law*, 12 CONN. INS. L. J. 1 (2005).

outlined in Section III, *infra*, is that it essentially causes insurers to completely abdicate their gate keeping role.

This section answers that question in a two step process. The first step will describe recent scholarship that calls into question whether insurers have ever fully occupied the gate keeping role. This is in contrast to some other studies that indicate the opposite.¹²⁷ The second step is to provide an economic argument for why the monitoring role of D & O insurance will not adequately punish or reward intransigent or compliant corporations, respectively.

A. D & O INSURERS AS GATEKEEPERS?

The recent work of Professor Tom Baker and Sean Griffith point out an interesting anomaly: In the vast majority of instances, insurers do not provide corporate governance.¹²⁸ As one of their interviewees stated:

You had asked me on the phone whether companies changed their behavior for the benefit of their D & O insurers. I don't think they are. I think the brokers sometimes can put lipstick on the pig, but that is a marketing feature. And it seems to me that however high D & O premiums climb, they are not going to climb high enough to get the companies to really, really pay attention.¹²⁹

This also is relevant to the discussion, *infra* § II.B. Even in instances where the insurer provides some services related to governance, they are generally ignored.¹³⁰ Thus, the governance role of D & O insurance is minor and whatever effect poor governance has on pricing is not adequate to change corporate behavior.

127. Clifford Holderness, *Liability Insurers as Corporate Monitors*, 10 INT. R. LAW & ECON. 115, 116 (1990).

128. See generally Tom Baker & Sean Griffith, *The Missing Monitor in Corporate Governance: The Directors' and Officers' Liability Insurer* § II.A., available at www.ssrn.com.

129. *Id.*

130. *Id.* at 16. Even those who had substantial loss prevention mechanisms in place at one time eliminated them because "[w]e couldn't show the discount..." *Id.* at 18.

B. PRICE AS A FAILED DETERRENT

A qualitative explanation is available. The D & O insurance market is characterized by lower regulation relative to other lines of insurance, lower barriers to entry and less orthodox underwriting processes. By its nature then, there is greater competitive pressure on premium pricing. Insurers, on the other hand, currently endeavor to price each insured according to their relative risk of loss, with the higher risk insureds thereby paying more for the same product as a lower risk insured. This can be viewed as a type of price discrimination.¹³¹

The goal of price discrimination is to capture consumer surplus. Consumer surplus, simply described, is the difference between the price a consumer is willing to pay and what they do pay.¹³² However, in order to capture consumer surplus, a firm must have some monopoly power over price levels. In a competitive industry, any increase of market price would drive the demand for the firm's product to zero. Conversely, a decrease of price below the market level would have similarly disastrous effects. This is because the market price is equal to the marginal cost of the good, so profit is already zero. Any downward deviation from this would cause a firm to lose money for every unit sold. Furthermore, ease of entry and exit in the market makes increasing market share virtually impossible. In addition, firms supply relatively small amount of goods to the market, with the result that production decisions are insufficient to affect market price. Thus, there is little incentive for any firm to decrease price below market levels.

131. Price discrimination is the charging of different customers different prices for the same or nearly the same product. There are classically three different types of price discrimination. First-Degree Price Discrimination is when a firm charges a customer the most he or she is willing to pay for the product (called the reservation price). In Second-Degree Price Discrimination, a firm charges a lower price upon the quantity consumed (so-called bulk discounts). This is generally considered the most common form of price discrimination. And Third-Degree Price Discrimination is when a firm divides the market into different groups with different demand curves and determines the prices for each group separately. In practice, a firm segments the market into large, discrete classes that are easily identifiable and charges each class a distinct price. . However, given the firm-by-firm underwriting in D & O insurance, it would be more accurate to view insurers as engaging in imperfect First-Degree Price Discrimination. The thesis of this paper then can be seen as advocating that insurers switch from this form of discrimination to Third-Degree Price Discrimination.

132. For an elementary treatment of Consumer Surplus and Price Discrimination, *See generally* Robert S. PINDYCK & DANIEL RUBINFELD, MICROECONOMICS (6th ed. 2004). For a more advanced treatment, *See* ELMAR WOFSTETTER, TOPICS IN MICROECONOMICS (1999).

If we view D & O premium pricing as a form of price discrimination, then the market structure becomes an integral part of the analysis. While by no means a perfectly competitive market¹³³, there is sufficient competitive pressure to limit the degree to which firms can price the premiums.¹³⁴ The more competitive the industry, the less aggressively insurers can punish bad risk for their poor corporate governance practices. For if they offer them a premium sufficiently high to compensate the insurer for absorbing the risk, there is another insurer who will offer the same coverage for less. This competitive pressure drives down the price and results in a lower premium.

The same can be said for low risks, as well. In instances where claims experience is low and profits are up, insurers are likely to be aggressive with respect to what they believe are good risks. As such, during hard markets, premiums drop across the board in an attempt to create market share. During soft markets, the same dynamics would drive up the premium of good risks more slowly than perceived poor risks.

The problem with the analysis in the last paragraph is that it assumes that good risks and bad risks can be differentiated perfectly so that any difference in premium, even after accounting for competitive pressures, roughly equate to the difference in the expected loss between the good and bad risk insureds. However, this is not a realistic assumption. No matter how much underwriting an insurer engages in, there is a substantial informational discrepancy between what the insurer knows and what the insured knows. Thus, for any firm an insurer classifies as low risk, there is a chance that it is a higher risk. Similarly, firms classified as high risk may in fact be low risk.¹³⁵

133. See Tillinghast 2005 Survey.

134. In fact, the two largest players in D & O insurance comprise over 50% of the market. It also bears noting that the insurance industry goes through underwriting cycles, where during some times premiums industry wide increase, followed by periods where premiums drop. These underwriting cycles are described well in Fitzpatrick, *supra* note 103. However, what is true in all environments is that competition for business is real and this has an impact on what insurers can charge potential insureds.

135. Of course firms that are truly low risk have every incentive to be classified as such, so it is unlikely that they would be misclassified. However, low risk firms may have some high risk characteristics such as past directors, type of industry, or some combination of other factors. This can be compared to auto insurance or credit scores. Just because an individual was once a high risk does not necessarily mean that they cannot now be low risks. But past performance informs present perceptions, so there is inevitably some inertia in risk-rating. This also provides an explanation for why during very profitable periods insurance companies are more willing to bet that a particular risk is no longer as high a risk as it appears.

In George Akerlof's seminal paper, *The Market for Lemons*, this dynamic is well illustrated.¹³⁶ When informational asymmetries exist in a market, that is, where one side possesses more information pertaining to a product than another, the side with more information has an incentive to pass off a low quality product as a high quality one.¹³⁷ This, in turn, slowly erodes the market for the high quality product until only low quality products remain.¹³⁸ In the same way, high risk firms have an incentive to appear to be low risk. Insofar as they are successful, insurers have little incentive to charge ostensibly low risk firms a lower premium. The end result is that all firms would be charged the same, high risk premium.

This extreme result has not occurred, however, because firms are obligated to reveal information about themselves.¹³⁹ Furthermore, insurance companies are not completely unable to differentiate low risk and high risk companies.¹⁴⁰ But what this does imply is that insurers have an incentive to charge low risk firms a higher premium than would be actuarially required to compensate for the risk acquired.

Finally, corporate demand for D & O appears to be relatively inelastic. While there is not much research to support this contention, indirect evidence does exist.¹⁴¹ First and foremost, the underwriting cycles create large swings in premium pricing,¹⁴² yet the vast majority of publicly traded corporations still purchase D & O insurance.¹⁴³ Second, though premiums

136. George Akerlof, *The Market for "Lemons": Quality Uncertainty and the Market Mechanism*, 84 Q. J. OF ECON. 488 (1970).

137. *Id.*

138. *Id.*

139. This occurs through SEC and state filings, etc.

140. For example, large market cap corporations are more susceptible to lawsuits than low market cap corporations. High growth companies and those that go through frequent mergers are also higher risk. See generally TILLINGHAST 2005 SURVEY.

141. See Tillinghast 2005 Survey, *infra* note 146. The basic idea here is that if the pricing was relatively elastic, there would be changes in market composition as a result of price movements. However, the percentage of firms, year over year, that continue to purchase D & O insurance suggest that, even with significant changes in premiums, demand is relatively constant, hence inelastic.

142. See Scott E. Harrington, *Tort Liability, Interest Rates, and the Insurance Cycle*, in BROOKINGS-WHARTON PAPERS ON FINANCIAL SERVICES: 2004 (Robert E. Liton & Richard Herring eds., 2004); J. DAVID CUMMINS, ET AL, CYCLES AND CRISES IN PROPERTY/CASUALTY INSURANCE: CAUSES AND IMPLICATIONS FOR PUBLIC POLICY (Scott E. Harrington & Robert W. Kleins, eds., 1991). See also Tom Baker, *Medical Malpractice and the Insurance Underwriting Cycle*, 54 DEPAUL L. REV. 393 (2005).

143. Tillinghast 2005 Survey. Note that the sample in the survey is not random, so may not be representative of the corporations in general. However, a substantial sample set exists, so very likely inferences can be drawn.

are not inconsiderable, if we look at the average cost of D & O insurance for large market cap companies, the cost represents far less than 1% of their total value.¹⁴⁴ Finally, as derivative actions frequently settle within D & O policy limits,¹⁴⁵ the purchase of D & O insurance trades a future indeterminate liability for a present known one. As firms, like people, are generally believed to be risk adverse, there is an additional incentive to purchase this insurance even in the presence of escalating prices.¹⁴⁶

Given the foregoing, market forces tend to support the view that the premium differences between low and high risk firms are not as large as their level of risk would indicate. The end result is that low risk firms are indirectly subsidizing high risk firms. The gap between the two premiums therefore may not be large enough for high risk firms to change their governance structure because the cost of doing so would be higher than the savings associated with lower premiums. This is further supported qualitatively by the recent scholarship of Tom Baker and Sean Griffith. In particular, one insurer had bundled their insurance policy with active attempts to improve corporate governance.¹⁴⁷ They discontinued the practice, however, because they could not show a benefit in the premium.¹⁴⁸

Thus, given the market structure of D & O insurance, the lack of demand for active assistance in improving governance¹⁴⁹ and the inability to effectively demonstrate a significant quantifiable benefit supports the position that D & O insurance policies do not fully further the deterrence effects of tort law. The other alternative, that D & O insurance provides an *ex ante* benefit to shareholders has been questioned by recent research, which demonstrates the anomalous result that D & O insurers neither

144. A more significant measure would be the cost as a percentage of revenue, but a review of the revenues of the Fortune 500 show that revenues and market cap are both several orders of magnitude larger than the average D & O insurance premium for large market cap companies.

145. James D. Cox, *Making Securities Fraud Class Actions Virtuous*, 39 ARIZ. L. REV. 497, 512 (1997). Roughly 96% of all cases settle within policy limits.

146. As with all things, there is a limit, but given the pervasiveness of D & O insurance, that does not appear to be a substantial issue at present. In fact, in the 2005 TILLINGHAST survey, 100% of responding corporations purchased D & O insurance. TILLINGHAST TOWERS PERRIN, 2005 DIRECTORS AND OFFICERS LIABILITY SURVEY 20, fig. 21(2006).

147. Tom Baker, et al, *The Missing Monitor*, note 128 *supra* at 514.

148. *Id.* at 18.

149. See Tom Baker, *The Missing Monitor*, note 128 *supra* at 515-517.

attempt to shape corporate governance practices before claims, nor attempt to manage costs during and after shareholder litigation is initiated.¹⁵⁰

However, there are reasons to doubt the efficacy of underwriters' ratemaking. In this section, current insurance underwriting practices will be discussed, with a particular focus on how D & O underwriting is different than more traditional lines of insurance. Second, it will be shown how heuristic substitutes for more complex evaluations increase outcome volatility. And finally, drawing an analogy to asset management research, this section will show how irrational optimism about one's own performance combined with constant corporate pressure to price competitively leads to the outcome that underwriters will, over the long run, consistently understate the risk of potential insureds.¹⁵¹

III. MODERN PORTFOLIO THEORY, VOLATILITY AND DIRECTORS' AND OFFICERS' INSURANCE UNDERWRITING

Modern Portfolio Theory is, at its most basic level, the theory of how to combine a group of assets, with the goal of achieving efficient returns.¹⁵² How this would apply to insurance underwriting is fairly straightforward. The goal would be to partition the group of insureds into several classes and create a standard insurance rate for those classes based upon several easily identifiable characteristics.¹⁵³ In some ways this imitates auto underwriting, although D & O underwriting could not fully achieve that degree of precision.¹⁵⁴ Whether some minor adjustments are made

150. *Id.* at Part II.C.

151. This is well demonstrated by the following quote following a discussion of fund managers' performance expectations: "We are reminded of a recent survey of the entering class of one of the countries top-rated colleges. When students were asked if they expected to finish in the top 10% of their class, 87.5% responded that they did." EDWIN J. ELTON, ET AL., MODERN PORTFOLIO THEORY AND INVESTMENT ANALYSIS (6th ed. 2003).

152. *See generally*, EDWIN J. ELTON, ET AL., MODERN PORTFOLIO THEORY AND INVESTMENT ANALYSIS (6th ed. 2003).

153. For example, market cap, industry type, stock classification (such as growth, income, etc).

154. This follows from a straightforward application of the Law of Large Numbers and the Central Limit Theorem. In auto insurance there are far more policyholders and thus the loss data is much more consistent from year to year. The number of companies purchasing D & O is incredibly small by comparison and loss exposure is far more variable.

subsequent to this partition is optional, although it would be well-advised to restrict it to some easily available data.¹⁵⁵

An analogy to indexed mutual funds accurately portrays the workings of this type of underwriting. An indexed mutual fund is usually tied to a particular stock market or stock markets.¹⁵⁶ For example, a fund indexed to the S & P 500 would purchase shares in companies in the exact proportion to the S & P 500. As a result, the indexed fund's return would be similar to the growth of the S & P year over year.

Yet, this methodology is far too simplistic to be workable by any multi-line insurer. MPT informs capital allocation decisions that help protect against peculiar market risk. An initial reaction to this may be skepticism. It would appear obvious that well-trained and intelligent mutual fund managers could actively manage a fund to superior performance. In the same way, skilled and intelligent underwriters could select a group of insureds with risk below the market average.

Research in mutual fund management calls into question the accuracy of this belief. First, mutual funds, on average, have performed worse than portfolios consisting of a *random* selection of assets.¹⁵⁷ Furthermore, actively managed funds generally do worse than passive funds, which can be considered a type of random fund.¹⁵⁸ Not only is it difficult to predict the future, actively managed funds have additional problems that have to be overcome: more non-diversified risk, greater management costs, higher

155. Previous claims experience, for example. The goal, however, is to minimize the expensive underwriting practices that add a great deal of time and expense, with perhaps small realized benefit.

156. They can actually be tied to just about any type of asset market, real or not.

157. See John McDonald, *Objectives and Performance of Mutual Funds: 1960-1964*, 9 J. FIN. & QUANT. ANALYSIS 311 (1974); Peter Williamson, *Measurement and Forecasting of Mutual Fund Performance: Choosing an Investment Strategy*, 28 FIN. ANALYST J. 78 (Nov./Dec. 1972); T.E. Crenshaw, *The Evaluation of Investment Performance*, 50 J.BUS. 462 (1977); Bruce Lehman & David Modest, *Mutual Fund Performance Evaluation: A Comparison of Benchmarks and Benchmark Comparison* 42 J. OF FIN. 233 (1987); Edwin J. Elton, et al, *Efficiency with Costly Information: A Reinterpretation of Evidence from Manager Portfolios*, 6 REV. OF FIN. STUD. 1 (1993). All but the last, however, suffer from survivorship bias. Survivorship bias is where the study overstates the return of mutual funds. This occurs because funds are studied over a period of time, say 10 years, and thus the researchers require the funds to be in existence for those ten years. Funds that failed during the interval are not evaluated. And funds that fail have, on average, well below average returns.

158. See Elton, et al, *supra* note 152 at 681 ("Although index funds have outperformed most active managers, most investors who hire active managers believe they can spot the manager who will outperform the index. This belief persists despite the fact that there is very little evidence that *superior performance is predictable* [*italics added*]").

transaction costs from increased asset turnover and more tax liability.¹⁵⁹ The last two reasons are particular to mutual funds, but the first two are equal concerns for underwriters. Underwriters not only have to outperform the market in risk selection, they must generate even higher returns to compensate for increased underwriting costs.

There is yet another danger. D & O underwriters currently acquire and evaluate a dizzying amount of information on potential insureds.¹⁶⁰ In economic environments of asymmetric information, there is a curious phenomenon called the “curse of knowledge.”¹⁶¹ This phenomenon basically states that individuals who possess a large amount of information are unable to completely differentiate good information from bad.¹⁶² The result is that more knowledgeable actors may perform worse than the actor with inferior information.¹⁶³ Combining this information loss with feedback shows little improvement.¹⁶⁴ Furthermore, there exists a principle-agent problem in that the “curse of knowledge” often results in weaker punishments for poor performance and inadequate rewards for good performance.¹⁶⁵

The application of this to underwriting is straightforward. Consistent with the discussion above of heuristic theory,¹⁶⁶ underwriters who possess too much information about a potential insured may unreasonably lend weight to certain variables and not adequately weigh other variables enough. As the amount of data increases, this problem may be exacerbated. The end result is that underwriters that possess less knowledge may perform better than their more knowledgeable peers.

The idea behind an indexing approach to D & O underwriting is relatively simple. The majority of D & O risk is tied to derivative

159. *Id.* at 680-681.

160. *See* Part I.

161. Colin Camerer, et al, *The Curse of Knowledge in Economic Settings: An Experimental Analysis*, 97 J. OF POL. ECON. 1232 (1989).

162. *Id.* at 1233

163. *Id.*

164. *Id.*

165. *Id.* at 1246. Incidentally, this may also strengthen the argument above relating to the poor governance oversight insurance companies have. Again we have an informational asymmetry and both good and bad corporate performance could rationally be explained by factors that absolve them of blame or approbation. Thus the benefits of good governance may not be fully manifest in the premium, diminishing the incentives of the firm to improve.

166. *See* Part II, *supra*.

litigation.¹⁶⁷ In fact, in 2005 and the first half of 2006, 93% and 92%, respectively, of all complaints alleged 10b-5 claims.¹⁶⁸ Furthermore, 88% and 90% of these claims alleged misrepresentations in financial statements.

¹⁶⁹ As a consequence, it is not too surprising that stock volatility is an important determinant in litigation activities. But if stock volatility can be utilized to assess litigation risk, it can also be utilized to underwrite D & O insurance. Supposing that is true, then, the first step in the underwriting process will be to partition the market into different “volatility tranches.” In order to fully appreciate the significance of this, however, some understanding of stock market volatility is in order.

The inherent problem with volatility is that it is not directly observable. This has lead to several different techniques by which it can be measured. A simple metric, historical volatility, can be calculated using the following formula:

$$\frac{1}{n} \left[\frac{1}{(n-1)} \sum_{i=1}^n \epsilon_i^2 \right]$$

Where $\epsilon_t = \text{LN}(S_t/S_{t-1})$, the natural log of the change in the stock price. The problem with this form of volatility is that it is inherently backward-looking; it says nothing about future or current prospects about volatility, which is predominantly what is of interest to D & O underwriters. Furthermore, it weights all periods equally, which may not be proper. Other types of historical volatility measures may used, such as Exponential Weighted Moving Average Volatility (or EWMA), which weight the volatility of more recent returns more, but they still suffer from the backward-looking issue. Alternative measures include both Autoregressive Conditional Heteroskedacity Model (ARCH) or the Generalized version (GARCH). Each of these have the advantage of a statistical forecasting framework, but further discussion will be omitted on each of these models to conserve a relatively simplicity. Suffice it to say that no matter how you slice it, historical volatility may not adequately suggest future litigation risk (though, since litigation does lag volatility, past volatility may be a harbinger of current litigation risk). To alleviate this problem, implied volatility can be used.

167. See CORNERSTONE RESEARCH, SECURITIES CLASS ACTION CASE FILINGS: 2006 MID-YEAR ASSESSMENT (2006).

168. *Id.*

169. *Id.*

Implied volatility is the volatility of a stock or index implied by its option. An option, in its simplest form, is a contract to buy or sell a stock or index¹⁷⁰ for a fixed price at some predetermined time in the future. The volatility implied by an option is a function of both the option's strike price and time to maturity. This does create a selection problem; which volatility observed is the proper one?

The impasse can be dealt with through the more advance financial models, of which the most common is probably the Heston Stochastic Volatility Model.¹⁷¹ Again, the specifics will be avoided, but the observation that should be taken away is that, given historical data, future implied volatilities can be observed.

Once we have implied volatilities, excess volatility can be determined. Excess volatility simply means, relatively to an industry baseline, how much of a given firm's volatility can be characterized as non-systemic. We would expect, on average, that a particular industry, such as financial or aerospace, would have a certain level of volatility and an associated ambient risk of derivative lawsuits. Firms that deviate from that baseline within the industry would then be expected to have either a greater or lesser risk of litigation depending on whether they have positive or negative excess volatility.

When this process has been completed, you will have a list of industry volatilities and individual firm excess volatilities. At the moment we are really only interested in the relative volatilities implied at the time the underwriting is being conducted. As such, this analysis has much in common with nonparametric statistics. From this list, industries and then firms can be classified into as many different risk classes as the underwriter desires. Once this has been conducted, historical experience of litigation vs. implied volatility levels can be used to assess current claim exposure for each tranche. Finally, depending on the insurer's risk tolerances, a portion of the market can be assessed as preliminarily insurable. Finally, premiums can be calculated in accordance with the various capital models insurers utilize that then take account the probable claims experience in each tranche.

This formulation is certainly reductive in its current form, but it does provide a basis by which a D & O underwriting model could be implemented and backtested to check its veracity. One particular benefit of

170. *Id.*

171. For example, see ROBERT L. McDONALD, DERIVATIVE MARKETS (2nd Ed. 2006), Chapter 23.

the model is its relative simplicity. It utilizes a framework that requires only publicly available information that also does not require substantial vetting of potential insureds. Though this is not to suggest no form of that is required; there are other exposures for which insurers should account. Litigation risk that is not tied directly to market performance is an example of this. But what this does allow is a baseline model that can then be tweaked to accommodate peculiar firm risk at knowable at little expense. This should keep underwriting margins low and help improve profitability.

A further concern is correlated risk. For example, insuring only a select industry with low volatility may seem like a reasonably safe activity, but if the volatility is highly correlated, then each firm may be exposed to elevated litigation risk should volatility spike. To protect against this, D & O insurers should aim to underwrite historically low-correlated risks, to help curb the possibility of this happening.¹⁷²

CONCLUSION

Directors' and Officers' insurance is a unique line of insurance. It is also relatively young. This youth is partially demonstrated by the myriad methods in which its underwriters price potential insureds.¹⁷³ Which underwriting method is the best cannot be precisely answered. What this paper has attempted to accomplish is to synthesize several aspects of economics, psychology, sociology, finance, insurance law and corporate governance to critically evaluate current underwriting practices in D & O liability insurance. The success of this analysis is predicated upon several assumptions.

First, underwriters are individuals of bounded rationality. Much of behavioral economics presupposes that due to lack of time or lack of ability, people do not make fully rational choices, in the classical economic sense of the word. Second, it is assumed that the D & O underwriting cycle exists and is, at least, partly explainable by behavioral and organizational characteristics of the insurance industry and its constituents. And the final assumption is that the lessons of Modern Portfolio Theory are moderately transferable to underwriting. There is, as discussed in the last section, at least some support for this assertion.

172. It is unlikely that negatively correlated risks are available. Equities are almost always positively correlated, so the best scenario is likely only low correlation.

173. See Baker, et al, *supra* note 38.

Several questions are left unanswered. What are the market dynamics of a D & O insurance market consisting of “indexing” underwriters and “non-indexing” underwriters? Would this create market share problems? Perhaps the nature of individual underwriting may make it difficult for the “indexing” underwriters to maintain market share. Perhaps this will result in a shift away from the current market dynamics of increased specialization and back towards more *carte blanche* underwriting, with each insurer occupying a smaller sliver of risk for a greater number of insureds. This paper does not address these issues, but their resolution is important to the value of the suggested type of underwriting.

STOLI ON THE ROCKS: WHY STATES SHOULD ELIMINATE THE ABUSIVE PRACTICE OF STRANGER-OWNED LIFE INSURANCE

*Eryn Mathews**

“The objection is not that wholesale murder will ensue. Such an assertion only trivializes the debate. The objection is the third party owner of the policy benefits only from the death of the insured. The essence of sound underwriting is that the owner of the policy and the insurer both are better off if the insured continues to live.”

Mike Nelson¹

“I have always depended on the kindness of strangers.”

Tennessee Williams²

INTRODUCTION

The life insurance market is a burgeoning field of sophisticated investment transactions. A life insurance policy, traditionally an illiquid asset, has developed into an asset-backed security which has proved quite profitable to investors and insureds alike. These transactions allow insureds under certain circumstances to sell their policies to investors. The development of this secondary market has injected competition into the life insurance business and resulted in better products with more options for consumers.

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1. Mike Nelson, *Insurable Interest Under Siege*, STEVE LEIMBERG’S ESTATE PLANNING NEWSLETTER #671 (2004) available at <http://www.leimbergservices.com> (last visited May 14, 2008).

2. TENNESSEE WILLIAMS, A STREET CAR NAMED DESIRE (Signet 1951).

Stranger-owned life insurance, also known as STOLI, is an outgrowth of this legitimate secondary market. It is a consequence of innovation and sophisticated investment planning, but has distorted the purpose of life insurance. It allows strangers to benefit from the death of an insured, to wager on the lives of others for profit. In STOLI transactions, this anticipated profit is the sole motivation for acquiring the life insurance. The potential risks STOLI transactions pose, not only for legitimate secondary market transactions and the insurance industry generally, but also for consumers and investors, need to be addressed. STOLI, however, is cleverly structured and has, until recently, evaded state regulation. State legislatures must confront this regulatory vacuum to counter the ever growing risks STOLI presents.

Part I of this note addresses the history and development of the secondary life insurance market. This section demonstrates the value of legitimate secondary transactions to the insurance market in contrast to the perversity of STOLI arrangements, emphasizing that regulation would be directed specifically at illegitimate STOLI transactions and not secondary market transactions generally.

Part II examines the risks of STOLI transactions for life insurance companies, consumers, and investors. This section also discusses the tax implications of STOLI investments. Analysis of the adverse consequences to all involved in a STOLI transaction, including the negative and distorting impact it has on the life insurance market, demonstrates the need for regulation and prohibition.

Part III explores the states' roles in regulating STOLI. Regulation of STOLI implicates states' enforcement of insurable interest laws. This Note analyzes both the minority and majority positions of states regarding insurable interest and how the prevalence of STOLI has resulted in a re-evaluation of these laws. This section also explores regulatory alternatives such as adoption of the National Association of Insurance Commissioners new model act limiting STOLI transactions.

Part IV emphasizes the spectrum of regulatory options available to states and the increasing need to apply such regulations to prohibit STOLI transactions. It argues that prohibiting STOLI is necessary because of the fundamental shift it creates in the life insurance paradigm and the fraudulent practices it promotes. Further, regulation of STOLI transactions would not limit legitimate secondary market transactions or curb property rights or contract rights of those who no longer require insurance because of altered life circumstances. Consequently, state law should be utilized to eliminate the abusive insurance practices embodied by STOLI.

PART I: WHERE IT ALL BEGAN

a. ORIGINS AND DEVELOPMENT OF STOLI

The development of the life settlement industry³ began with the AIDS epidemic in the late 1980s.⁴ At that time, HIV/AIDS victims required extensive, continuous treatment. A victim's chance of survival was minimal even with access to quality care. In addition to its devastating physical impacts, HIV/AIDS was financially straining and often overwhelming. The harsh reality of HIV/AIDS made access to funds a necessity if one hoped to receive treatment and survive. This necessity resulted in the creation of the secondary life insurance market which took a traditionally illiquid asset, life insurance, and made it possible for the insured to exchange his interest in the policy for cash.⁵ Thus, life insurance was transformed into an asset-backed security known as a viatical settlement.⁶

In a viatical settlement the policyholder ("viator"), who has contracted HIV/AIDS or another terminal disease, directly or indirectly⁷ sells his interest in his life insurance policy to an investor.⁸ The investor's payment in return for the policy provides the viator with immediate access to funds.⁹ Typically, the viator is paid the present value of his policy. The present value depends on the viator's life expectancy, the face value of the policy,

3. STOLI transactions grew out of the life settlement industry and both life settlements and STOLI are secondary market transactions.

4. Florence Bih Shu-Acuaye & Elisabeth Divine Reid, *Viatical Settlement Industry: Does Mutual Benefits Render It Terminal*, 7 TRANSACTIONS: TENN. J. OF BUS. L. 7, 10 (2005).

5. *Id.* Viatical settlements give insureds access to death benefits that would normally be unavailable to them.

6. A viatical settlement is defined as the purchase of a terminally ill person's life insurance policy, by an investor or investment company, for a certain percentage of the policy's face value. SEC v. Life Partners, Inc., 87 F.3d 536, 537 (D.C. Cir. 1996).

7. Most viatical settlement transactions contain intermediate investors, broker firms, promoters or financial institutions which evaluate the worth of the policy, market the investment to secondary investors, and provide loans for the purchase of the policy. The result is that multiple parties often have an interest in the death of a single viator. BARRY D. FLAGG, THEINSURANCEADVISOR.COM, INC., STRANGER-ORIGINATED LIFE INSURANCE: FREE INSURANCE? FOUND MONEY? A GOOD INVESTMENT? A SCAM? WHAT IS IT ANYWAY?, 1-2 available at <http://www.theinsuranceadvisor.com/documents/STOLIWhitePaper-Final.pdf>.

8. SEC v. Mut. Benefits Corp., 408 F.3d 737, 738 (11th Cir. 2006).

9. *Id.*

and the cost of future premiums and administrative costs.¹⁰ Upon the death of the viator, the investor receives the proceeds of the insurance policy. His gain is the difference between the death benefit received and his payment to the viator plus premium payments and administrative costs.¹¹

Thus, viatical settlements provided HIV/AIDS patients with a much needed service and injected healthy competition into the market. Insurance companies began offering accelerated death benefits as a means of competing with viaticals.¹² The result was a competitive life insurance market which benefited consumers and responded to their needs. These insurance developments combined with medical advances that increased the life expectancy of the insured, however, reduced the rate of return on investments and thus diminished the appeal of viaticals to investors.¹³ The viatical industry responded to this decline in demand by broadening its consumer base.¹⁴ Viatical settlements now encompass any insured who has a life expectancy of less than two years.¹⁵ Currently, most states have enacted Viatical Settlement Acts to regulate the industry.¹⁶

Life settlements are an outgrowth of the viatical settlements industry.¹⁷ A life settlement, much like a viatical, provides the insured the opportunity to gain financial liquidity through the sale of his life insurance policy. Instead of selling the policy for medical reasons, however, the insured seeks to sell the policy based on a change in life circumstances. Examples

10. SEC v. Life Partners, Inc., 87 F.3d 536, 537 (D.C. Cir. 1996).

11. *Id.* The court defines an investor's profit as the difference between "the discounted purchase price paid to the insured and the death benefit collected from the insurer, less transaction costs, premiums paid, and other administrative expenses." *Id.* If the viator lives longer than expected the profit is correspondingly reduced. See Bih Shu-Acquaye & Reid, *supra* note 4, at 7.

12. An accelerated death benefits rider "provides terminally ill individuals with the immediate right to receive a small percentage of their death benefit" and thus enabled insurance companies to compete with viatical settlements. See Robert H. Heinrich, J.D. & Bradley K. Feldman, J.D., *Wet Paper: Giving Secondary Market for Life Insurance a Bad Name*, FEE ADVISORS NETWORK 2 (May 2007) available at <http://investor.financialcounsel.com> (last visited Oct. 10, 2008).

13. Heinrich & Feldman, *supra* note 12, at 3; Bih Shu-Acquaye & Reid, *supra* note 4, at 11.

14. Heinrich & Feldman, *supra* note 12, at 3.

15. *Id.*; Sachin Kohli, *Pricing Death: Analyzing the Secondary Market for Life Insurance Policies and its Regulatory Environment*, 54 BUFF. L. REV. 279, 281 (2006).

16. Westlaw 50 State Statutory Surveys, Life Insurance -- Viatical Settlements (August 2007) available at www.westlaw.com (last visited Oct. 10, 2008). Further, as of June 16, 2005 forty-seven states regulated viaticals as securities. Bih Shu-Acquaye & Reid, *supra* note 4, at 11.

17. Kohli, *supra* note 15, at 281.

include divorce, death of a spouse, retirement, disability, or bankruptcy.¹⁸ The industry targets policyholders who are 65 or older with a life expectancy between two and twelve years.¹⁹

An insured engaged in a life settlement transaction typically sells his policy for a sum greater than its cash surrender value but less than the death benefit.²⁰ The price offered takes into account the administrative costs of maintaining the policy -- primarily continued payment of premiums. The death benefit is ultimately paid directly to the investor, rather than to the initial insured, and the profit is computed just as in a viatical settlement.²¹ The life settlement industry has filled the vacuum left by viatical settlements and is flourishing.²² The current market is estimated at thirteen billion dollars and is projected to exceed one hundred and sixty billion dollars in the future.²³

STOLI²⁴ could be considered the illegitimate offspring of the viatical and life settlement industry. STOLI transactions occur when elderly persons who do not already own life insurance decide to purchase a policy at the behest of investors and brokers.²⁵ The investors initiate the life

18. National Association of Insurance and Financial Advisors, 1 *STOLI Alert* 1, 3-4 (March 2007) available at www.naifa.org (last visited Oct. 10, 2008). Typically, an insured is looking to enter into a life settlement when a change in their financial condition or their health has occurred. Heinrich & Feldman, *supra* note 12, at 3.

19. Generally, a life settlement is desirable when: (1) the policy has been owned for longer than two years; (2) the policy has a lower premium obligation as well as a cash surrender value; and (3) candidate is over the age of 65 with "an impaired life expectancy". Heinrich & Feldman, *supra* note 12, at 3.

20. *Id.* The cash surrender value of a policy is the money an insurance company would be willing to pay the insured if he were to surrender his policy to the company. Kohli, *supra* note 15, at 288. However, when an insured's health declines the surrender value of the policy is less than the market value making it a profitable sale. *Id.*

21. See *supra* note 11 and accompanying text.

22. Kohli, *supra* note 15, at 298 ("Demographic trends within the United States indicate that the market is positioned for tremendous growth." The article cites such factors as increased life expectancy that correlates to less need for life insurance policies. It also predicts that the market for these transactions should increase at three times the rate of the general population in the next twenty-five years).

23. R. Mark Keenan & Steven Seltzer, *Life Settlements – Investors Beware Complete Your Due Diligence Before Buying* (November 2006) available at www.andersonkill.com (last visited Oct. 10, 2008).

24. STOLI is also referred to as speculator-initiated life insurance ("SPIN-LIFE") and investor-initiated life insurance ("IOLI").

25. STOLI transactions generally deal with universal life insurance policies. See, Peter Nash Swisher, *The Insurable Interest Requirement For Life Insurance: A Critical Reassessment*, 53 *DRAKE L. REV.* 477, 478 (2005); Terry M. Magady, *Practice Tips: Selling Life Insurance on the Secondary Market*, 28 *LOS ANGELES LAWYER* 14, 14 n.7 (2006).

insurance transactions with strangers at the point of sale.²⁶ The investors often characterize the life insurance purchase as “free insurance”, “risk-free”, or “no-cost”, and offer other financial incentives such as upfront cash bonuses to induce purchase.²⁷ Investors or agents often advertise STOLI through the internet and at fancy solicitation forums such as on cruises.²⁸ The target population is wealthy people who are 65 years or older with a limited life expectancy.²⁹ The targeted consumer agrees to purchase a life insurance policy with a large face value with funds provided by the investor through an outside financial institution.³⁰ A two-year non-recourse³¹ loan is typically used to purchase the policy and to fund the insured’s payment of premiums.³² At the end of two years, the policy is usually assigned to the investor.³³ The assignment functions, to some extent, as a repayment of the initial loan plus interest. While assignment of

26. STOLI unlike life settlements involve mainly private rather than institutional investors.

27. Stephen R. Leimberg, *Stranger-Owned Life Insurance: Killing the Goose That Lays Golden Eggs!*, THE INS. TAX REV. 811, 811 (May 2005) available at http://taxprof.typepad.com/taxprof_blog/files/2005-6866-1.pdf (last visited Oct. 10, 2008); Heinrich & Feldman, *supra* note 12, at 3; Ted Anagnoson, *Is Death a Commodity?*, CAL. ST. UNIVERSITY EMERITUS & RETIRED FACULTY ASS’N REPORTER 1,3 (March 2008).

28. Anagnoson, *supra* note 27, at 3.

29. Kohli, *supra* note 15, at 284. Prime candidates also have a life expectancy of less than fifteen years. *Id.* See also Written Statement of David M. Lewis, Representative of the Life Settlement Institute, Addressing the U.S. House of Representatives Committee on Financial Services Oversight and Investigations Subcommittee, at 3 (February 26, 2002) available at www.financialservices.house.gov (last visited Oct. 10, 2008).

30. Kohli, *supra* note 15, at 3.

31. Premium non-recourse financing means that the loan issued to pay the premiums on the policy is secured only by the policy itself. If the borrower defaults the lender may only receive the insurance policy and can not go after the borrower’s other assets or finances. Louis S. Harrison, *Death Don’t Have No Mercy When It Comes To Non Recourse Premium Financed Life Insurance*, 41ST ANNUAL SOUTHERN FEDERAL TAX INSTITUTE 1, 13 (Sept. 18-22, 2006).

32. Though non-recourse financing is typically used in STOLI transactions recourse loans are also made in connection with such arrangements. *Insurer Acts to Rescind Free Life Insurance*, LEIMBERG INFORMATIONAL SERVICES (September 2006) [hereinafter LEIMBERG]. Recourse or semi-recourse financing is being used more frequently as insurance companies are refusing to issue policies to applicants who have received non-recourse financing due to its association with STOLI transactions. FLAGG, *supra* note 7. The loan, whether recourse or not, is made for two years in order to cover the contestability period on a life insurance policy. Heinrich & Feldman, *supra* note 12, at 3. Once that period passes an insurance company can only attempt to rescind the policy on the grounds of fraud or lack of insurable interest. *Id.*

33. The two year waiting period is utilized in order to avoid state wet ink laws and contestability clauses in the policies themselves. Heinrich & Feldman, *supra* note 12, at 3.

the policy is not technically required, it is inevitable given the size of the loan plus interest and premiums an insured would have to repay and continue to pay if he chose to maintain the policy.³⁴ An insured's other, less viable, options include: (1) continuing to pay the premiums himself and repaying the initial loan plus interest; or (2) selling the policy to a third party and using the return to repay the loan plus interest³⁵. Neither of these two options is as feasible or as frequently exercised as ceding the policy to the investor without having to repay any portion of the loan or interest.

b. STOLI VERSUS LEGITIMATE LIFE SETTLEMENTS: WHAT ARE WE REGULATING?

The Supreme Court iterated the basic premise for distinguishing legitimate life settlements from STOLI in *Connecticut Mutual Life v.*

34. A recent complaint filed in the United States District Court for the Central District of California, *Lincoln National Life v. Fishman*, emphasizes this point stating, "[i]ndeed the money used to purchase the policies was lent at such a usurious and exorbitant interest rate that when the note becomes due, the trust will not be able to repay the loan and will have no effective alternative but to forfeit the policies and assign them to the investor". National Association of Insurance and Financial Advisors, 2 *STOLI Alert* 1, 4 (March 2008) available at www.naifa.org (last visited Oct. 10, 2008). In this case Fishman, a retired physician took out three insurance policies each with a ten million dollar death benefit. *Id.* Prior to applying for the policies it is alleged that Fishman accepted one million dollars from Mutual Credit Corporation. *Id.* Further, Mutual Credit Corporation provided all the financing in the form of a non-recourse loan. *Id.* The finance charge on the loan was more than 100 percent of the amount loaned assuring that then only way to satisfy the debt was the transfer of the three policies. *Id.* See also, Alan Jensen & Stephan R. Leimberg, *Stranger-Owned Life Insurance: A Point/Counterpoint Discussion*, 33 THE AMERICAN COLLEGE OF TRUST & ESTATE COUNSEL JOURNAL 110, 130 (Fall 2007). The authors describe a fraudulent scheme in which a broker, Joseph Gennaco, peddled free life insurance with an upfront cash bonus to those willing to purchase and then turnover life insurance policies. *Id.* The scheme involved use of a two year non-recourse loan secured only by the policy. *Id.* The interest rate on the loan was prohibitively high such that at the end of the two year period the insured had no choice but to turn the policy over to the lender. *Id.*

35. When the insured initially purchases the policy it is in connection with a particular investor or investment firm. Unless that firm declines to purchase the policy because of changed circumstances it is highly unlikely the insured will sell the policy to a third party. This is because in addition to finding a new investor the amount of the loan and interest rate are usually too high for the insured to make a profit upon sale. See Jensen & Leimberg, *supra* note 34, at 130.

Schaefer.³⁶ The Court held that, “[a]ny person has a right to procure insurance on his own life, and assign it to another, provided it not be done by way of cover for a wager policy” and that “the essential thing is that the policy shall be obtained in good faith, and not for the purpose of speculating upon the hazard of a life in which the insured has no interest.”³⁷ Under this reasoning, legitimate life settlements are those in which the insurance was procured in good faith and the initial intention was to purchase insurance for oneself or a loved one. Accordingly, traditional viatical and life settlements are lawful and serve legitimate purposes. These financial transfers were not planned prior to the purchase of the policy. Rather, the insured legitimately obtained life insurance for the financial benefit and protection of family members or dependents. As circumstances within their lives changed, access to those benefits became necessary and so the insurance market adapted to those needs.³⁸ Without these secondary market alternatives, policyholders’ life insurance would remain an illiquid asset.³⁹

STOLI transactions, however, inherently conflict with the Supreme Court’s reasoning, because the consumer’s purchase of an insurance policy is a cover for the investor’s and consumer’s true intent. People participating in these transactions do not want life insurance. It is a financial transfer of the policy from inception to an unrelated party, literally a stranger. It is speculation on the life of another. STOLI is a means of circumventing states’ insurable interest laws by having the insured purchase the policy in his own name, but with the investor’s money and for the investor’s ultimate benefit.⁴⁰ These transactions have broad and

36. See generally *Conn. Mutual Life Ins. Co. v. Schaefer*, 94 U.S. 457 (1876).

37. *Id.* at 457, 460. See also *Warnock v. Davis*, 104 U.S. 775, 781 (1881) (applying the *Schaefer* Court’s distinction and ruling that “[t]o hold it valid for the whole proceeds would be to sanction speculative risks on human life, and encourage the evils for which wager policies are condemned”); *Travelers Cas. & Sur. Co. v. Northwestern Mut. Life Ins. Co.*, 480 F.3d 499, 501-02 (7th Cir. 2007)(citing *Schaefer* in a unanimous decision rejecting a corporate party’s claim to death benefits from an insurance policy on a stranger’s life).

38. National Association of Insurance and Financial Advisors, 1 *STOLI Alert* 1, 3-4 (March 2007) available at www.naifa.org (last visited Oct. 10, 2008).

39. Kohli, *supra* note 15, at 280.

40. A permutation on these deals utilizes the loophole created by relaxed insurable interest laws which allows charities to take policies out on an individual’s life or to be named a beneficiary. In this type of transaction, “investors ‘borrow’ the insurable interests of charities to purchase insurance coverage on the lives of the organization’s older, wealthy, charitable-minded, and generous donor[s]”. Leimberg, *supra* note 27, at 813. These arrangements are commonly referred to as COLI transactions. *Id.* Further, STOLI transactions may be achieved through the use of irrevocable trusts and banks as well.

negative implications for all parties involved as well as for primary and secondary life insurance markets. State action is necessary to prevent this bad faith speculation on human life and its untoward consequences.

PART II: WHY STOLI SHOULD BE PROHIBITED

The practical and legal distinctions between legitimate secondary life insurance market transactions and STOLI provide a basis for regulation. It is the risks STOLI poses to consumers, however, that make state action and elimination of STOLI essential. These risks directly harm consumers through potential confidentiality breaches, misleading marketing strategies including false promises of financial security and certainty, and health risks. STOLI derivatively harms consumers through its impact on insurance companies and tax consequences which result in market distortions, affect availability and affordability of life insurance, potentially negate positive tax treatment and consequently may result in a fundamental shift of the life insurance paradigm. These risks are discussed in greater detail below.

a. IMPACT OF STOLI ON THE INSURANCE MARKET

Life insurance is a business. Thus, insurers calculate everything from a business perspective including premiums, value of policies, savings, and who will be insured. In pricing life insurance, companies analyze and base prices on multiple factors including mortality and lapse rates.⁴¹ The first factor, mortality rates, is integral to pricing insurance policies as well as to the rate of return for STOLI investors.⁴² It is generally based on medical information and is important because a life insurer cannot raise premiums due to deterioration of an insured's health.⁴³ This factor remains virtually unchanged by the emergence of life settlements and STOLI transactions.

The second factor, lapse rates, has the most potential to negatively affect availability and pricing of life insurance policies for the elderly. Under a regular life insurance contract, a certain percentage of

41. Cynthia J. Crosson, et. al., *Fatal Attraction: Risks in the Secondary Market for Life Insurance*, FITCH, INC., FITCH RATINGS LTD 1, 7 (2007) available at www.life-investor.eu. (last visited Oct. 10, 2008).

42. The rate of return for STOLI transactions or any viatical or life settlement is inversely proportionate to the health of the insured. Therefore, a decline in the insured's health increases profits for the investor(s). *Id.*

43. *Id.*

policyholders will surrender their policies or allow them to lapse.⁴⁴ In these cases the insurer retains all premiums which have been collected and never pays out a death benefit.⁴⁵ Insurance companies have come to rely on this percentage and use the information to calculate premiums for all the policies they issue.⁴⁶ STOLI transactions distort this percentage because STOLI is designed to ensure that policies never lapse and that the death benefit is always paid, just not to the original insured.⁴⁷ This occurs because investors can usually afford to pay premiums and maintain the policy until the initial insured's death. In order to compensate for this additional and incalculable risk, life insurers will need to increase premiums, permanently, for all life insurance applicants, including those who genuinely need it, particularly the elderly.⁴⁸

Another reason STOLI is likely to increase life insurance premiums is the cost and resources insurance companies require to litigate STOLI issues such as fraud and misrepresentation. Insurance companies have already begun expending valuable resources litigating whether STOLI policies must be paid.⁴⁹ Increased litigation costs, coupled with increased

44. *Life Partners, Inc. v. Morrison et al*, 484 F.3d 284, 295 (4th Cir. 2007).

45. Heinrich & Feldman, *supra* note 12, at 2.

46. Morrison, 484 F.3d at 295. See Charles Duhigg, *Late in Life, Finding a Bonanza in Life Insurance*, N.Y. TIMES, Dec. 17, 2006 (noting that companies rely on policies lapsing so much so that on ninety percent of the policies companies never pay a death benefit and that last year (2006) "insurance companies reduced their financial exposure by \$1.1 trillion when 19.8 million policyholders stopped paying premiums". Accordingly, death benefits were paid on only 2.2 million policies).

47. Heinrich & Feldman, *supra* note 12, at 3-4.

48. *Id.* This change in lapse rates will eventually force companies to revise previous statistics and assumptions. This distortion is expected to drive up the overall cost of life insurance most notably for the elderly. *Id.*

49. *Id.* at 4 (noting that New York Life and Annuity Company and John Hancock brought legal actions alleging fraud because the policies were purchased as part of a STOLI transaction). See also complaint filed in the United States District Court for the Central District of California, *Lincoln National Life v. Fishman*, in which Lincoln National requests rescission or voidance of three ten million dollar life insurance policies because of alleged misrepresentations by the insured and the investors' lack of insurable interest. National Association of Insurance and Financial Advisors, *supra* note 34, at 4. See generally *Life Product Clearing, LLC v. Angel*, 530 F. Supp. 2d 646 (S.D.N.Y. 2008) (finding that investors were not entitled to the proceeds of a \$10 million life insurance policy because the policy was always intended to benefit the investors and is therefore in violation of insurable interest laws and public policy).

regulation and monitoring costs, will drive up life insurance prices generally.⁵⁰

Moreover, because of this market distortion and increased payment of death benefits, there are potential solvency issues. Insurance companies plan on a certain number of policies lapsing and so reserve funds accordingly.⁵¹ Potentially, with so many people unexpectedly collecting on very large policies, an insurance company will not have set aside enough funds to pay all the claims, legitimate and illegitimate. While companies may adjust to some of these changes in the future, current unanticipated collections pose a threat.

STOLI's effect on insurance companies is important because it adversely affects the death benefits of those who legitimately purchased life insurance or who want to purchase life insurance in the future. It does so by potentially diminishing an insurance company's ability to pay claims and by driving up the average cost of life insurance. Accordingly, STOLI's effect on insurance companies negatively reshapes the current life insurance market for consumers.

b. IMPACT OF STOLI ON CONSUMERS/INSURED

STOLI directly and derivatively harms consumers, particularly the elderly. The offer of a risk-free investment with a large payoff is enticing,

50. Heinrich & Feldman, *supra* note 12, at 3-4. The emergence of life settlements and STOLI markets will lead to the creation of new monitoring and tracking systems which may affect the pricing of ordinary policies. *Id.* John Hancock Life Insurance Co. of Boston is a prime example of the increased monitoring insurance companies are enacting while waiting for states to play a larger regulatory role. Sara Hansard, *Hancock moves against 'stranger-owned' policies*, INVESTMENT NEWS (September 25, 2006) available at www.investmentnews.com (last visited Oct. 10, 2008). John Hancock has modified a number of forms including two new forms now required of applicants over the age of 70 that must be approved by each state. *Id.* Further the company is requiring new applications and certification forms for policies to be owned by trusts. *Id.* All of this increases an insurance company's overhead and is reflected in the price all consumers have to pay not just those participating in STOLI transactions. *See also*, Jensen & Leimberg, *supra* note 34, at 123 (stating, "[i]nsurers are forced unnecessarily to spend millions of dollars to monitor and filter these fraudulent transactions" and questioning why insurers, a victim in the process, should be forced to single-handedly regulate STOLI).

51. E-mail from Doug Head, LISA Executive Director, regarding Comments on NCOIL Model on Life Settlements (February 20, 2007) available at www.lisassociation.com (last visited Jan. 18, 2008). *See also* Jensen & Leimberg, *supra* note 34, at 112 (noting that 89% of universal life policies did not pay benefits).

but misleading. The individual risks of these arrangements are not being regulated, nor are the resulting market distortions which adversely affect the availability and cost of life insurance for consumers.

First, STOLI arrangements raise concerns regarding the relationship between the insured and investors. The STOLI relationship is much more intrusive than that of an insured to an insurance company. Under this multi-party arrangement, the investors may require more regular examinations as their profit is directly determined by the health of the insured.⁵² Further, a STOLI transaction involves an insured, a broker, and an investor at the very least. Only the insured has an interest in his continued vitality. While concern that an investor will murder an insured to increase profit may seem implausible, history and human nature advocate against such ready dismissals.⁵³ Therefore, while the chances of an investor murdering an insured are rather small there is no guarantee that it will not happen.

A larger concern is maintaining the confidentiality of an insured's identity and medical history. This information may be circulated to

52. FLAGG, *supra* note 7.

53. In truth, the basis for prohibiting wagering contracts is not so historically distant as one might hope, consider, C. DiMassa, *2 Arrested in Homeless Life Insurance Scam, Pair Are Accused of Obtaining Policies on two men who later died in hit-and-run accidents*, L.A. TIMES (May 19, 2006). The article provides: "[t]wo women were arrested Thursday after they allegedly befriended two homeless men, took out 19 life insurance policies on them and filed claims worth more than \$2.2 million after the transients mysteriously died in hit-and-run pedestrian accidents in Los Angeles". See also *Stenson v. Lambert*, 504 F.3d 873, 879-880 (Wash. 2007) (Defendant was convicted and sentenced to death for the murder of his wife and business partner. Stenson, in financial difficulty, had taken out a \$400,000 life insurance on his wife prior to killing her); *Williams v. Ozmint*, 494 F.3d 478, 485-86 (4th Cir. 2007) (in a petition for Habeas corpus the court noted that defendant was in dire financial straits and recently declared bankruptcy. Further, less than a month before the murders of both his son and wife Williams "substantially increased" their life insurance coverage naming himself as the beneficiary. Williams was convicted and sentenced to death for both murders.); *Milton v. Wainwright*, 407 U.S. 371, 374 n.1 (1972) (Defendant confessed that "Minnie Lee Claybon (the murder victim) and myself had an insurance policy together. So I started thinking about the insurance and the money that I could get if something happened to her. I knew that I could use the money if something happened...So I drove the car into the river and she was killed". The defendant was convicted of murder.). These are just a few incidents and are representative of the potential for both strangers and loved ones to murder in order to make a profit. It is fair to speculate that if family members are enticed to kill spouses and children an even greater temptation would exist with respect to strangers.

unsavory investors over whom the insured has no control.⁵⁴ Providing this information exposes the insured to myriad breaches of confidentiality which could jeopardize his life or otherwise expose him to harm. For example, in *Stranger-Owned Life Insurance: A Point/Counterpoint Discussion*, Stephen Leimberg notes that on April 5, 2007, “the federal court for the Southern District of Florida released information on a case in which Columbian drug cartel members bought life settlements to launder drug money.”⁵⁵ This case demonstrates that STOLI investors are unknown figures who have absolutely no interest in the health or wellbeing of the insured. Based on the potential attenuated chain of investors, an insured may not know who has an interest in his death.⁵⁶ Moreover, the investor has a legal right to assign the policy to whomever he chooses, such that an insured cannot prevent a person from having an interest in his death.⁵⁷ These risks are the direct consequence of turning human lives into investments.

Second, the insured is giving up the benefits of obtaining and owning a life insurance policy in the future. There is a maximum amount of aggregate coverage insurance companies are willing to issue to any individual.⁵⁸ STOLI transactions are designed to maximize profits for all participants, so insureds are often encouraged to procure the largest policy possible irrespective of the insured’s future insurance needs. In doing so, the consumer uses up his insurability.⁵⁹ Uninformed or ill-informed participants may unwittingly sacrifice these rights and ruin any chance of obtaining needed life insurance after they participate in a STOLI transaction.

Moreover, there are many uncertainties accompanying STOLI transactions. The contestability period of a life insurance policy plays a key

54. See J. Alan Jensen & Stephan R. Leimberg, *supra* note 34, at 118-19 (stating that “original investors have the legal right (and often the intent) to sell the policy individually or in a block with other policies immediately to a different group of investors. There is no legal limit to how many times the policy on your life can be sold or to whom. Therefore, the insured has no control or knowledge of who will own it and be its beneficiary”).

55. *Id.* at 119.

56. *Id.*

57. Leimberg notes that the only way for an insured to prevent future assignment of the policy is by contractual agreement. *Id.* at 126. There is no incentive for an investor to agree to profit limiting provisions and given the unequal bargaining power between the investor and the potential insured it is unlikely that a STOLI company would. *Id.*

58. Heinrich & Feldman, *supra* note 12, at 4.

59. *Id.*

role in determining when, how, and if the death benefits are distributed.⁶⁰ There are two possibilities: the insured will either die during the contestability period or after it. If he dies during the contestability period, then the initial designated beneficiary will receive the death benefits, but the loan that the insured received in order to pay the premiums will need to be repaid plus interest and administrative costs to the lenders.⁶¹ Therefore, family members will not receive the full benefit of the policy. Additionally, there is a chance that the insurance company will try to rescind the policy based on the attempted STOLI transaction.⁶² If the insurance company succeeds, the family may be responsible to the investor for the loan.⁶³ Therefore, the potential result is expensive liabilities and litigation for the decedent's family.

Alternatively, if the insured survives the contestability period, even though the investors have agreed to finance the loan, there is often no guarantee the investors will purchase the policy.⁶⁴ The insured's life expectancy may have changed and consequently the price originally offered may decrease accordingly, or the investors may no longer be interested in the policy.⁶⁵ In this situation, the lender may seek repayment of the initial loan from the insured because it will no longer be repaid upon transfer of the policy.⁶⁶ Thus, an insured may suffer an overall loss on the transaction.⁶⁷ Lastly, even if the investor purchases the policy upon the insured's death, his estate may still be liable to investors for the value of the policy.⁶⁸

60. See *supra* notes 32 & 33 and accompanying text.

61. Heinrich & Feldman, *supra* note 12, at 3. The lender is a creditor of the decedent's estate such that it is entitled to repayment of the loan. Because the loan is typically non-recourse the estate has two options, either repay the debt or the lender is entitled to assignment of the policy as the policy was collateral for the loan. If recourse financing was utilized, as is the growing trend, the decedent's family is responsible for full repayment of the loan plus any accumulated interest. See *supra* notes 31 & 32 and accompanying text.

62. If the insurance company succeeds in rescinding the policy because of a misrepresentation regarding the STOLI transaction then the nature of the loan often shifts from non-recourse to recourse rendering the decedent's family liable for up the full face value of the policy. See Harrison, *supra* note 31, at 14.

63. *Id.*

64. *Id.*

65. *Id.*; Jensen & Leimberg, *supra* note 34, at 117.

66. See Jensen & Leimberg, *supra* note 34, at 117.

67. *Id.* This danger is mitigated if the transaction utilized non-recourse financing, as the lender's only recourse is to acquire the policy. Harrison, *supra* note 31, at 13.

68. See *supra* note 62 and accompanying text.

Given the potential illegality of STOLI transactions, insurance companies and states are increasingly challenging the validity of such agreements and insurance companies' responsibility to pay the benefit.⁶⁹ This uncertainty, often lost on consumers, is not overlooked by investors who require consumers to execute complex legal documents guaranteeing payment of the proceeds.⁷⁰ Therefore, when lenders and investors are denied recovery by insurance companies, they often have recourse against the estate.⁷¹ The one-sided nature of these provisions suggests that insureds do not understand the risks they are taking on, or lack the bargaining power to rewrite the STOLI contract to reduce these risks. What may seem like a good way to increase savings and provide relatively quick income can instead lead to devastating debt and financial insecurity.⁷²

In addition to fraud, confidentiality breaches, and health risks, STOLI has the potential to make life insurance prohibitively expensive for those who genuinely need or want it. Consumers cannot protect themselves from these fundamental market shifts. Further, consumers are the main target of STOLI and the harm it creates. Therefore, while STOLI may benefit some wealthy consumers and investors, the costs of treating humans as commodities adversely affects the entire population and exceeds any benefit received through these transactions. The only way to protect consumers is through state action and prohibition.

c. IMPACT OF STOLI ON INVESTORS

Investors also must clearly understand the risks of STOLI transactions. As participants, their finances are exposed to the risk that the investments will either be unprofitable or nullified. This is perhaps a familiar risk for some investors, but given the marketing of STOLI arrangements as safe investments, conservative investors with limited resources may be misled into investing.⁷³ There are two levels of potential fraud that may affect the risk of investment and the rate of return.

69. It is much harder to challenge the validity of the policy once the contestability period has expired. *See* Heinrich & Feldman, *supra* note 12, at 3. However, most challenges to successfully alter the nature of the financing from non-recourse to recourse, involve misrepresentations in the insurance application or fraud on the insurer. It is unclear whether the nature of the financing would shift based on a denial for lack of insurability. *See* Harrison, *supra* note 31, at 14.

70. Jensen & Leimberg, *supra* note 34, at 117.

71. *Id.*

72. *Id.*

73. Leimberg, *supra* note 27, at 811.

The first level of fraud may be perpetrated by either the insured or the investment broker/company.⁷⁴ Investment return relies upon accurate estimates of life expectancy, so if an insured lies about his good health to gain more compensation, the investor's profit may decrease. Theoretically, companies promoting STOLI and corresponding brokers should evaluate an insured's life expectancy independent of what is reported, but that is not always the case.⁷⁵

This form of fraud upon investors is often perpetrated by the STOLI company or broker. Often the STOLI company handles most, if not all, aspects of the investment transaction, e.g., evaluation of life expectancy and payment of premiums.⁷⁶ Therefore, the investment company retains most of the knowledge and control over the transaction. Power often leads to abuse as evidenced by one of the most recent and biggest frauds upon investors, addressed by the Eleventh Circuit in *SEC v. Mutual Benefits Corporation*.⁷⁷ In *Mutual Benefits*, the company defrauded approximately 29,000 investors by using misleading life expectancies in predicting when the insureds would die.⁷⁸ As insureds outlived these expectancies, the company used money from new investors to pay the premiums on the older policies rather than the ones they purportedly invested in, much like a pyramid scheme.⁷⁹ Investors lost millions of dollars, including many people's life savings.⁸⁰

74. An indictment issued by United States Attorney McGregor W. Scott of the Eastern District of California evidences the type of fraud that is perpetrated upon investors. The indictment alleges a scheme to defraud approximately 500 investors in twenty states for over twenty-five million dollars. McGregor W. Scott, U.S. Atty, *Eight Defendants Indicted On Major Viatical/Life Settlement Fraud Scheme*, E.D. CALIFORNIA (August 23, 2007). The indictment alleges that the company involved made false and misleading statements regarding the safety and risk of the investment as well as that they were not required to be licensed. *Id.* at 2.

75. *SEC v. Mut. Benefits Corp.*, 408 F.3d 737, 739 (11th Cir. 2005) cert. dismissed (*Mut. Benefits Corp. v. SEC*, 2007 U.S. LEXIS 8978 (U.S. 2007)).

76. *Id.*

77. *Id.*

78. *Id.*; National Association of Insurance and Financial Advisors, 1 *STOLI Alert* 1, 5 (June 2007) available at www.naifa.org (last visited Oct. 10, 2008); Patrick Danner, *Viaticals are now subject to regulation*, RTG CONSULTANTS, LLC available at www.herald.com (last visited Oct. 10, 2008). The 29,000 investors purchased 7,322 life insurance policies valued at a total of 1.5 billion dollars. *Id.*

79. National Association of Insurance and Financial Advisors, 1 *STOLI Alert* 1, 5 (June 2007) available at www.naifa.org (last visited Oct. 10, 2008). Those responsible for the Mutual Benefits scandal were sentenced to five years in prison and ordered to pay \$826 million in restitution damages to investors. *Id.*

80. *Id.*

The second level of fraud is on the insurer. As insurance companies have become increasingly aware of STOLI transactions, they have begun to tailor the application process to detect such arrangements.⁸¹ In order to avoid tripping the STOLI wire, insureds are often told to lie or omit information to induce the insurance company to issue a policy. Misrepresenting one's intent when directly questioned qualifies as a misrepresentation of material fact, if the insurance company would not have issued the policy but for the lie or omission. This is insurance fraud, punishable as either a misdemeanor or felony depending on the state.⁸² Also, the insurance company may contest the policy under insurable interest laws or even rescind it entirely based on these misrepresentations. New York Life and Annuity Corporation recently rescinded a one million dollar policy on the grounds that the trust involved was created solely for the benefit of investors rather than the insured.⁸³ These investors were the beneficiaries and premium payors on the policy but had no familial or economic interest in the life of the insured.⁸⁴ This action emphasizes not only the importance of disclosure regarding STOLI transactions but more importantly the risk to both the investor and the insured's estate when participating in such arrangements. Though with any insurance policy there is some risk that it may be rescinded, that risk is multiplied with STOLI because the legality and regulatory requirements remain unsettled.

d. TAX IMPLICATIONS OF STOLI

How the Internal Revenue Service ("IRS") will treat money acquired through STOLI transactions as well as the transfer of the policy itself remains unsettled. Tax analysis includes treatment of the initial financing loan, the payment on exchange, and the receipt of the death benefits by

81. As noted in Section II.a, insurance companies have great incentive to prevent STOLI transactions.

82. Jensen & Leimberg, *supra* note 34, at 115.

83. See LEIMBERG *supra* note 32. The complaint alleges a violation of New York's insurable interest laws. *Id.* The company notes that the only remedy available to the company is to rescind the policy and return the premiums plus interest. *Id.* See also *New Obstacles to Stranger-Owned Life Insurance Transactions ("SOLI")*, GREENBERG TRAURIG SPECIAL REPORT (January 2007) available at www.Gtlaw.com (last visited Oct. 10, 2008).

84. LEIMBERG, *supra* note 32.

investors.⁸⁵ Resolution of these issues will greatly affect all involved in STOLI arrangements including the profit to investors and the financial compensation of consumers. The tax consequences of these transactions may eliminate any promised financial benefit.⁸⁶

Typically, life insurance proceeds received as death benefits are not included in the beneficiary's gross income or the insured's estate and are thus tax-free money.⁸⁷ The policy reason behind the tax exemption is that the proceeds are meant to protect against death and provides for one's family.⁸⁸ Conversely, based on this policy, if an insured decides to receive proceeds for his life insurance policy prior to death, then a portion of the proceeds will be included in his income and consequently taxed.⁸⁹ With STOLI, it is unclear how the gains from the sale of the policy and the proceeds from the policy will be taxed. Further, whether proceeds and financial gain are taxed as capital or ordinary income makes a significant difference as capital gains are taxed at a much more favorable rate than ordinary income.⁹⁰

There are several possible tax treatments for STOLI transactions, all of which lack the typically positive treatment life insurance proceeds receive

85. A whole paper could be written on the potential tax consequences of STOLI transactions. The purpose of this article, however, is to give only an overview of the problems that make state legislation and regulation of STOLI transactions imperative.

86. See Raymond J Lehman, *House Subcommittee Leaders Want Treasury Guidance on STOLI*, BEST WIRE SERVICES (Nov. 28 2007). Lehman reviews a letter to Treasury Secretary Paulson from several representatives expressing concern about STOLI and stating that "because tax rules governing settlements can be complex, including regulations on cancellation of indebtedness income, they raise the potential that an insured or his or her heirs could face an unexpected tax liability". *Id.* "Some transactions may be classified under federal tax law as 'split-dollar' life insurance, while insured also may be unaware of their tax liability for any cash promotions they receive". *Id.*

87. I.R.C. §101(a)(1) (1986).

88. Leimberg, *supra* note 27, at 819 (quoting Vaughn Henry, "It's because life insurance protects widows, widowers, and children from becoming paupers when the breadwinner dies that it isn't taxable. But that may change if Congress or the Treasury Department thinks life insurance is becoming nothing more than a wager.").

89. I.R.C. §101(a)(2) (1986); I.R.C. §72(e) (1986). The portion subjected to tax is the amount above the principal paid for the policy. This may be complicated by an annuity or similar arrangements.

90. Under the IRC capital gains receive much more favorable treatment, being taxed only at a 15% rate. This is a very low capital gains rate that is subject to change in the future. The treatment of death benefits, capital versus ordinary gain or the tax rate for capital gains, under such an investment scheme does make a difference as it directly impacts the rate of return on the investment. FLAGG, *supra* note 7, at 29.

under the Internal Revenue Code (“IRC”).⁹¹ First, the IRS may treat the initial loan as an option agreement and payment.⁹² Traditionally, loans are not taxed under the IRC.⁹³ By treating the initial loan as a payment option, however, the IRS could tax the entire amount of the loan which could potentially exceed any initial financial incentive offered by the investor.⁹⁴ This creates a liquidity problem for the insured and may result in unanticipated financial problems. Conversely, if the payments are considered loans, then any amount the insured is not required to repay may be taxed as cancellation of indebtedness income.⁹⁵ This means that the insured will be taxed on the portion of the loan that was forgiven, which may or may not exceed the price he was paid for the policy. Regardless of whether the policy is considered a loan, the insured will be taxed to the extent that cash value received exceeds premiums paid; thereby reducing the insured’s gain as well.⁹⁶ Therefore, the same liquidity issues arise whether the transaction is treated as a payment option, subject to debt-forgiveness, or treated as ordinary income.

Further, recent IRS regulations called “split dollar regulations” have emerged.⁹⁷ A split dollar arrangement is as:

Any arrangement between an owner and non-owner of a life insurance contract that satisfies the following criteria:

(i) Either party to the arrangement pays directly or indirectly all or a portion of the premiums on the life insurance contract including

91. I.R.C. §101(a)(1) (1986).

92. Heinrich & Feldman, *supra* note 12, at 8.

93. This is because a loan is not viewed as income. The debtor has to pay the money back such that there is no basis in the loan and consequently no taxable gain.

94. Heinrich & Feldman, *supra* note 12, at 3.

95. I.R.C. §108 (1986).

96. Again the tax analysis gets rather complicated. The idea is simple, the tax consequences of STOLI transactions are currently uncertain but may result in negating most and in some cases all of the insured’s gain, leaving the insured with next to nothing and the investors with millions upon the insured’s death.

97. Margaret Gallagher Thompson, J.D., *The Final Split-Dollar Regulations*, J. OF ACCOUNTANCY (February 2004) available at www.aicpa.org (last visited Oct. 10, 2008)(noting a split-dollar arrangement exists when there is one policy between an owner and non-owner and one of the party pays the premiums and is entitled to recover the payment through the death benefit). See Joshua E. Husbands & J. Alan Jensen, *Split Dollar Life Insurance Funding: You Mean People Still Do That*, HOLLAND & KNIGHT LLP 1, 3 (August 30, 2007).

a payment by means of a loan to the other party that is secured by the insurance contracts;

(ii) At least one of the parties to the arrangement paying premiums under the paragraph above is entitled to recover (either conditionally or unconditionally) all or any portion of those premiums and such recovery is to be made from, or is secured by, the proceeds of the life insurance contract.⁹⁸

If this definition is satisfied, then the death benefit of an insured is included in the insured's gross income and taxed accordingly.⁹⁹ Due to the broad definition of split dollar arrangements, these regulations potentially apply to STOLI transactions.¹⁰⁰ STOLI transactions typically utilize a non-recourse loan such that the premiums of the policy are paid by a third party and the third party is entitled to recover those premiums from the proceeds of the life insurance which secures the loan.¹⁰¹ Consequently, STOLI proceeds and profits could face adverse tax treatment under the split dollar regulations.¹⁰²

Most importantly, STOLI transactions have the potential to strip all life insurance of favorable tax treatment. If life insurance primarily becomes an investment vehicle rather than a means of providing protection and benefits to one's family, then the reason for tax free treatment evaporates. This fundamental shift in the life insurance paradigm threatens the security most have come to expect by individually investing in life insurance and results in costs to those who seek life insurance for legitimate purposes and depend on the corresponding beneficial treatment of its proceeds.¹⁰³

98. Husbands & Jensen, *supra* note 97, at 4.

99. FLAGG, *supra* note 7, at 29.

100. "The definition under the final regulations is so broad that arrangements not previously considered split-dollar may well be swept within its scope." Thompson, *supra* note 97, at 3.

101. Split dollar treatment has a greater impact if a trust is involved. With a trust, the insured would be taxed on both the death benefit minus premiums paid as well as assessed a gift tax. FLAGG, *supra* note 7, at 30.

102. Due to the abusive practices of STOLI the IRS could determine that STOLI qualifies as a split dollar arrangement in order to deter insureds from entering into these transactions. See FLAGG, *supra* note 7, at 67.

103. The risk of allowing STOLI to continue is the potential loss of tax benefits afforded to life insurance because of its social merits. *An Update on Recent Developments*

PART III: STATES' ROLE IN PREVENTING STOLI

Based on these concerns, states have an interest in eliminating STOLI transactions. An important role of government is to protect citizens from fraud, harassment, and abuse. States have a responsibility to prevent the exploitation of elderly residents by institutional and individual investors and the brokers who seek them out.¹⁰⁴ Another role of government is to ensure that citizens, both as insureds and investors, do not deceive insurance companies by circumventing insurable interest laws and generally concealing their intentions with regard to the transfer and assignment of policies. As we saw, however, the most important reason the state has for preventing STOLI is to ensure that citizens have the ability to purchase necessary life insurance. Given the detrimental consequences of STOLI, the state has a greater responsibility to its citizens to prevent the continued use of STOLI.¹⁰⁵

Involving Stranger Owned Life Insurance (STOLI), MARKET INTELLIGENCE REPORT (December 2007). While there are no current proposals to alter the taxation of life insurance the Treasury has been required to institute an extensive two-year Investor Owned Life Insurance study. *Id.* Further, the President's Tax Advisory Panel's 2005 report recommended a plan that "would remove all the favored buildup from life insurance and annuities." *Id.* "With mounting deficits, a PAYGO regime in which all new expenditures must be offset with new revenue and efforts to pass a permanent [alternative minimum tax] 'fix' we must continue to seriously consider the legislative vulnerability of life insurance." *Id.* (citations omitted).

104. Several states have issued alerts to warn residents, especially the elderly about STOLI. See Matt Brady, *Texas Sounds Alarm On Wave Of STOLI Solicitations*, NAT'L UNDERWRITER, LIFE & HEALTH, Vol. 111, Iss. 24 pg. 6 (June 18 2007); Texas Department of Insurance, COMMISSIONER'S BULLETIN #B-0054-07 (December 21, 2007) available at <http://www.tdi.state.tx.us/bulletins/2007/cc53.html> (last visited Oct. 10, 2008); *Consumer Alert: Stranger-Originated Life Insurance*, ILLINOIS DIVISION OF INSURANCE available at <http://www.idfpr.com> (last visited Oct. 10, 2008) (advising consumers to proceed with caution regarding STOLI and stating that the Illinois Division of Insurance does not approve of these transactions); *Consumer Alert: Stranger-Originated Life Insurance (STOLI)*, OHIO DEPARTMENT OF INSURANCE available at <http://www.ohioinsurance.gov> (last visited Oct. 10, 2008); North American Securities Administrators Association, State Securities Regulators Issue Senior Investor Alert (September 10, 2007) available at www.nasaa.org (last visited Oct. 10, 2008).

105. Jennifer A. Lann, *Viatical Settlements: An Explanation of the Process, An Analysis of State Regulations, and an Examination of Viatical Settlements as Securities*, 46 DRAKE L. REV. 923, 930 (1998). States have the ability to enact licensing and disclosure requirements, minimum price regulations, general contract provisions, penalties for violation, and any other provision or regulation the state sees fit. *Id.* at 931.

Finally, the state has the power and ability to regulate these relationships, as they relate to the business of insurance under the McCarran Ferguson Act ("MFA").¹⁰⁶ The ability of states to regulate life settlements and consequently STOLI transactions was affirmed in *Life Partners, Inc. v. Morrison et al.*¹⁰⁷ In *Life Partners*, the Fourth Circuit held that state regulation of viaticals regarding price minimums constituted the business of insurance because the focus of the regulation was on the insurance contract.¹⁰⁸ The Supreme Court has since denied review.¹⁰⁹ The Fourth Circuit opinion reinforces the state's regulatory power with respect to the consumer protection side of the secondary life insurance market and should be equally applicable to the regulation of STOLI.

a. DO STOLI TRANSACTIONS VIOLATE STATE INSURABLE INTEREST LAWS?

i. *History of Insurable Interest Laws and Wagering Contracts*

Life insurance, historically, has only been enforceable where the contract includes an insurable interest in the life of the insured.¹¹⁰ Prior to the creation of the insurable interest requirement in 1774,¹¹¹ persons were allowed to take policies out on anyone's life.¹¹² Thus, life insurance contracts were viewed not as investments but as bets on another's life. The perceived danger in this wager was that a person, with no interest in the continued life of the insured and who would gain by the insured's death, might be induced to kill the insured to make a profit or win a bet.¹¹³ When the United States adopted the English common law system, it adopted the insurable interest requirement as well. While the initial intent of the requirement, deterring murder, is important, there are equally important concerns such as fraud, consumer protection, and maintenance of the legitimacy of both the primary and secondary life insurance markets.

106. 15 U.S.C. §§ 1011-13 (2008).

107. See generally *Life Partners, Inc. v. Morrison et al*, 484 F.3d 284 (4th Cir. 2007).

108. *Id.*

109. *Life Partners, Inc. v. Morrison*, 2007 U.S. LEXIS 12749 (Dec. 3, 2007).

110. Swisher, *supra* note 25, at 478.

111. The British Parliament in 1774 passed a statute providing that "any life insurance contract without an insurable interest in the life of the insured" would be void. *Id.* at 481

112. Policies could be taken out on persons charged with serious crimes, famous people, and/or the elderly. *Id.*

113. *Id.*

Accordingly, the Supreme Court has recognized the validity of the insurable interest requirement,¹¹⁴ as have state legislatures and courts.¹¹⁵

Under these statutes and the common law, the general requirements of insurable interest are: “love and affection” for the insured; that the applicant be “closely related by blood or law” to the insured; or “in the case of other persons, a lawful and substantial economic interest in the continued life, health, or bodily safety” of the insured is present.¹¹⁶ The existence of an insurable interest is generally only required at the time the contract is executed, not at the time of the insured’s death.¹¹⁷ The requirement must be met, however, regardless of who purchases the insurance but generally only becomes a concern when someone besides the insured is taking out, acquiring, or inducing the purchase of the policy on the insured’s life.¹¹⁸

114. *See* Connecticut Mut. Life Ins. Co. v. Schaefer, 94 U.S. 457, 460 (1876)(stating that “mere wager policies – that is, policies in which the insured party has no interest whatever in the matter insured, but only an interest in its loss or destruction – are void, as against public policy...[i]n this country, statutes to the same effect have been passed in some of the States; but where they have not been, in most cases either the English statutes have been considered as operative, or the older common law has been followed...[a] man cannot take out insurance on the life of a total stranger, nor on that of one who is not connected with him as to make the continuance of the life a matter of some real interest to him”)

115. *See e.g.*, ALASKA STAT. § 21.42.090(2) (2007); ARIZ. REV. STAT. ANN. § 20-1104(A)-(C) (2007); ARK. CODE ANN. § 23-79-103 (WEST 2007); CAL. INS. CODE §§ 280, 10110 (WEST 2007); DE. INS. CODE §§ 2704-05 (WEST 2007); GA. CODE ANN. § 33-24-3 (WEST 2007); HI REV. STAT. § 431:10-204 (2007); IDAHO CODE ANN. § 41-1804 (2007); KAN. STAT. ANN. § 40-450 (2007); KY. REV. STAT. ANN. §§ 299.150, 304.14-040 (WEST 2007); ME. REV. STAT. ANN. § 2404 (2007); MD CODE ANN. INS. § 12-201 (WEST 2007); MI. COMP. LAWS ANN. § 500.2211 (WEST 2007); MISS. CODE ANN. § 83-5-251 (WEST 2007); MONT. CODE ANN. § 33-15-201 (2007); N.M. STAT. ANN. § 59A-18-4 (WEST 2007); N.Y. INS. LAW § 3205(B)(McKINNEY 2007).

116. Swisher, *supra* note 25, at 480 (citing Robert H. Jerry, II, Understanding Insurance Law 40, at 292-93 (3d ed. 2002)).

117. This is of course the provision STOLI transactions exploit to avoid the application of state insurable interest laws. However, this reality can and should be changed by states’ revision of current insurable interest statutes or through stricter interpretation. *See* Leimberg, *supra* note 27, at 813 (noting that unlike property and casualty insurance the owner must only have an insurable interest in the insured when the policy is purchased and need not exist upon collection of the death benefit).

118. Swisher, *supra* note 25, at 484. “Every person has an unlimited insurable interest in his or her own life”. *Id.* Regarding STOLI transactions the focus of insurable interest is not on whether a person can take out a policy on his own life or designate his own beneficiary. Rather, it is whether he may do so with the intention to sell the policy and if that investor has an insurable interest.

STOLI transactions do not involve relationships characterized by love or affection, nor do they include family members. The investors are strangers who may never even meet the insured. Therefore, the only means of satisfying the insurable interest requirement is if a "lawful and substantial economic interest in the continued life, health, and bodily safety of the person insured"¹¹⁹ is demonstrated. The types of relationships that satisfy this prong are business relationships such as between partners, with regard to employees whose existence are critical to the operation of a business,¹²⁰ or creditors with respect to debtors.¹²¹ In contrast, STOLI investors do not have a substantial interest in the continued life of the insured; in fact their interest is directly adverse to the health of the insured and they do not qualify under any of the three exceptional categories.¹²²

Based on this premise, if the STOLI contracts were executed by the third party investor for his benefit, then they would be void as against public policy. STOLI transactions, however, are sophisticated enough to circumvent the requirement of insurable interest upon issuance of the policy.¹²³ There are several schemes STOLI employs. The most common are: the insured takes out the policy himself and subsequently assigns the policy to the investor or names the investor as a beneficiary; an irrevocable trust is used as the beneficiary of the policy and the investor is the beneficiary of the trust; or a charity takes a policy out on the insured's life with his consent.¹²⁴ Another alternative is to exploit the creditor/debtor relationship established by the initial loan. As a creditor, the investor may be designated as a beneficiary of the policy and thereby entitled to a portion of the death benefits.¹²⁵ It is precisely because a majority of states only require insurable interest at the execution of the contract, and allow for the

119. *Id.* at 498.

120. This type of insurance is commonly known as key-man or key-woman insurance. It is an exception to insurable interest laws which most states have accepted. Charity Rush, *Corporate-Owned Life Insurance(A/K/A/ 'Dead Peasant' or 'Dead Janitor' Policies): Has Texas Buried The Insurable Interest Requirement?*, 41 HOUS. L. REV. 135, 140 (2004).

121. Swisher, *supra* note 25, at 511-20.

122. *Id.* at 510

123. The use of deceit and technicalities should not be allowed to circumvent the spirit of insurable interest laws. Such subterfuge should not be rewarded by a windfall. *See* Leimberg, *supra* note 27, at 813 & 817.

124. Many states have modified insurable interest statutes and provided that charities have an insurable interest in a donor's life. Leimberg, *supra* note 27, at 813.

125. Swisher, *supra* note 25, at 519. There is a question of how much of the proceeds the creditor is actually able to collect. Most courts limit collection to some reasonable amount. *Id.* at 520. What qualifies as a reasonable amount is unclear but courts often look to the proportion of the death benefit to the amount owed as a guide. *Id.*

free transfer and assignment of the policy, that STOLI practitioners have been able to circumvent insurable interest obligations.

ii. Public Policy Concerns Regarding State Prohibition of STOLI

All fifty states regulate insurable interest with respect to the purchase, assignment, or change in beneficiary regarding the life insurance contract.¹²⁶ Each state defines insurable interest in conjunction with its public policies. Some insurable interest laws are stricter than others.¹²⁷ As discussed, some states require an insurable interest at inception but not on assignment based on priorities favoring the insured's property rights¹²⁸ and freedom of contracting and resale.¹²⁹

Prohibition of STOLI, however, does not necessarily curtail an insured's ability to sell his policy if he does so legitimately, within the scope of the law.¹³⁰ Prohibition is directed instead at the acquisition of insurance for the sole purpose of selling it to investors. Further, any changes to insurable interest laws can carve out exceptions for legitimate secondary market transactions.¹³¹ Therefore, at least in the instance of STOLI, freedom of property and contract concerns may be accommodated. STOLI can be prevented through stricter application of insurable interest

126. See *supra* note 110 and accompanying text.

127. Rush, *supra* note 120, at 141.

128. *Amick v. Butler*, 12 N.E. 518, 520 (Ind. 1887); *Grigsby v. Russell*, 22 U.S. 149, 156 (1911)(stating that to “deny the right to sell except to persons having such an [insurable] interest is to diminish appreciably the value of the contract in the owner’s hands”); *Hawley v. Aetna*, 125 N.E. 707, 712 (Ill. 1919)(noting that there is no “reasonable basis” for preventing an insured from selling or assigning his policy to anyone who would pay more than the cash surrender value “which the company is willing to pay”).

129. This contrasting principle’s objective is to provide the insured with a valuable liquidity of investment that he otherwise would be deprived of if prevented from assigning his policy. Roy Kreitner, *Speculations of Contract, or How Contract Law Stopped Worrying and Learned to Love Risk*, 100 COLUM. L. REV. 1096, 1121 (2000).

130. STOLI transactions occur when a person buys insurance with the intent to sell it to a third party. See *Rylander v. Allen*, 53 S.E. 1032, 1034 (Ga. 1906)(stating that evidence of a “preconceived intent to assign the policy would tend to invalidate the policy”); *Steinback v. Diepenbrock*, 52 N.E. 662, 664 (N.Y. 1899)(noting that in determining a parties intentions “all the facts and circumstances may be proven, and if it appears that the parties intended by the contract to enable a third and uninterested party to speculate on the life of another, the court will declare such a contract invalid, not because of the assignment, but in spite of it”). Decisions emphasize that transactions which are a mere cover for wagering contracts or to circumvent the insurable interest laws will be invalidated. Kreitner, *supra* note 129, at 1121.

131. See *infra* note 176-80 and accompanying text.

laws and the alteration of ineffective insurable interest laws¹³², while legitimate viatical and life settlement transactions are preserved.

iii. State Insurable Interest Laws

A minority of states maintain strict insurable interest laws that require the assignee or beneficiary to have an insurable interest in the insured at the time of death.¹³³ Assignments have been held void for lack of insurable interest even if the transfer was made in good faith and was not intended as a wagering contract.¹³⁴ This prohibition remains regardless of any surrounding circumstances that would justify the transaction or render it valid in other states.¹³⁵ This rule, that the policy is void if no insurable interest exists at death, has been affirmed even in cases where the insured paid all the premiums himself,¹³⁶ and regardless of the lapse of time between issuance and assignment,¹³⁷ or whether assignment was made

132. State insurance departments have begun to define what constitutes STOLI transactions. New York issued an opinion which defined it as “the procurement of insurance solely as a speculative investment for the ultimate benefit of a disinterested third party.” OP. OFF. GEN. COUNSEL (N.Y. Dec. 19, 2005). Utah has defined it as a scheme “whereby a third party initiates, arranges the transaction, and ultimately expects to receive the proceeds of the insurance policy” and Louisiana has defined it as a scheme involving premium financing where the investor “contemporaneous with the initiation of the life insurance policy, taking an interest in the death benefit above and beyond the repayment of principal and interest of the loan”. Head, *supra* note 51.

133. C.T. Drechsler, *Validity of assignment of life insurance policy to one who has no insurable interest in insured*, 30 A.L.R.2d 1310 (West 2007)

134. RICHARD A. LORD, 17 WILLISTON ON CONTRACTS §49:122 (4th ed. 2008).

135. See e.g., *Helmetag’s Adm’r v. Miller*, 76 Ala. 183 (Ala. 1884)(stating that a policy issued to one on his own life could not be assigned by him to a person or entity having no insurable interest in his life); *Missouri Valley L. Ins. Co. v. McCrum*, 12 P. 517 (Kan. 1887)(affirming decision that assignment of policy to a person without insurable interest is void against public policy and stating that such assignment constitutes a fraud upon the insurance company); *Shaw v. M. Livingston & Co.*, 169 S.W.2d 612 (Ky. 1943)(noting that where the transaction constitutes a wagering contract the policy was void and the insurance company was not required to pay the death benefit); C.T. Drechsler, *Validity of assignment of life insurance policy to one who has no insurable interest in insured*, 30 A.L.R.2d 1310 (West 2007)(noting that the minority view has generally prevailed in Kentucky); *Mayo v. Hartford Life Ins. Co.*, 220 F. Supp. 2d 714 (S.D. Tex. 2002)(stating that it is against public policy “of the State of Texas to allow anyone who has no insurable interest to be the owner of a policy of insurance upon the life of a human being”); *Crismond’s Adm’r v. Jones*, 83 S.E. 1045 (Va. 1915)(holding that an assignment is invalid if no insurable interest exists).

136. *Schlamp v. Berner*, 51 S.W. 312 (Ky. 1899).

137. *Missouri Valley L. Ins. Co. v. Sturges*, 18 Kan. 93 (Kan. 1877).

pursuant to a prior agreement.¹³⁸ States that follow the minority rule include: Alabama, Kansas, Kentucky, Missouri, Pennsylvania, and Texas.¹³⁹

The majority of states allow assignment as long as it is not intended to circumvent the law and it is not a cover for a wagering contract.¹⁴⁰ Forty-four states follow this rule.¹⁴¹ Here, as with the stricter minority rule, it is the spirit of the law which is emphasized.¹⁴² Majority jurisdictions, like the minority, will render a policy void if the transaction was made in bad faith, was fraudulent, or was simply a means of circumventing the wagering prohibition.¹⁴³ The majority states, however, focus on the public policy that an insured should be able to sell his policy on the market for the most advantageous deal.¹⁴⁴ This position, in theory, should prevent STOLI, but in reality it has not. This reality has been worsened by the loosening of insurable interest laws in order to accommodate key-man insurance as well as insurance transfers for charities, and religious or educational institutions.¹⁴⁵ As STOLI becomes increasingly prevalent, however, states are beginning to pull back on those accommodations and are now trying to curb the practice of STOLI through stricter enforcement of insurable interest laws.

b. STATE ATTEMPTS TO RESTRICT STOLI UNDER INSURABLE INTEREST LAWS

138. *Bromley's Amdrs. v. Washington L. Ins. Co.*, 92 S.W. 17 (Ky. 1906); *Thomas v. Connecticut Mut. L. Ins. Co.*, 257 P. 727 (Kan. 1927). It should be noted that under the majority rule the policy would be void as well.

139. RICHARD A. LORD, 17 WILLISTON ON CONTRACTS §49:122 (4th ed. 2008).

140. Drechsler, *supra* note 133, at 42; RICHARD A. LORD, 17 WILLISTON ON CONTRACTS §49:122 (4th ed. 2008).

141. RICHARD A. LORD, 17 WILLISTON ON CONTRACTS §49:122 (4th ed. 2008) (noting that many jurisdictions have permitted assignment where there is no insurable interest).

142. *Id.*

143. "[I]t should be made clear, an assignment to an assignee devoid of any insurable interest in the life of the insured is only prima facie valid. Suspicious circumstances will cause a court to deny validity to colorable assignment as being only a cloak for a wagering transaction." *Id.*

144. *Grisby v. Russell*, 222 U.S. 149 (1911).

145. In 2004 several states were poised to enact legislation which would expand insurable interest laws to accommodate charities, religious institutions and the like. *Recent Developments in Insurable Interest and Investor Owned Life Insurance*, SL043 ALI-ABA 339, 376 (West 2007). However, only two states, North Carolina and Tennessee, ended up enacting such legislation. The states of Alabama, Florida, Louisiana, Maryland, New York, and Oklahoma also proposed similar legislation that was never enacted. *Id.*

States have begun to target and address the insurable interest problem either through legislation or opinions issued by state insurance departments.¹⁴⁶ Several States have issued opinions regarding STOLI in light of insurable interest requirements.¹⁴⁷ The first state to issue an opinion was New York.¹⁴⁸ The opinion addressed N.Y. INS. LAW §3205 and stated: “New York has a strong public policy against speculation on the death of individuals. Accordingly, one may not, with limited exceptions, take out a policy of life insurance on the life of another.”¹⁴⁹ What is unique about New York’s insurable interest law is that it not only requires an insurable interest at the time the policy is procured, but it also prohibits the solicitation or assignment of life insurance policies procured for the benefit of an investor not having an insurable interest.¹⁵⁰ Section

146. Maine will consider a bill regarding STOLI and consumer protection in the upcoming year. *Rep. Brautigam’s Bill to Scrutinize Questionable Trend in Life Insurance Markets*, US STATE NEWS (October 30, 2007). *See also* OP. OFF. GEN. COUNSEL (N.Y. Jun. 3, 2003)(regarding Insurable Interest, N.Y. Ins. Law §3205); James J. Donelon, Insurance Commissioner, BULLETIN NO. 06-05 (September 5, 2006); D. Kent Michie, Utah Insurance Commissioner, BULLETIN 2006-3 (July 10, 2006) *available at* www.insurance.utah.gov (last visited May 14, 2008); W.W. Deal, Director of the State of Idaho Department of Insurance, BULLETIN NO. 07-03 (April 2, 2007). Other states have issued warnings regarding free insurance offered to senior citizens. *See supra* note 97.

147. National Association of Insurance and Financial Advisors, *STOLI Alert* 1. 3-4 (March 2007) *available at* www.naifa.org (last visited Jan. 18, 2008).

148. OP. OFF. GEN. COUNSEL (N.Y. Jun. 3, 2003)(regarding Insurable Interest, N.Y. Ins. Law §3205). *See also*, Trevor Thomas, *New York Department Bars Investor-Owned Life Scheme*, NAT’L UNDERWRITER, LIFE & HEALTH, Vol. 110, Iss. 7 pg. 1 (February 20, 2006). Further in an opinion issued in December of 2005 General Counsel found four possible violations of New York law with respect to STOLI transactions. John Gallo, J.D., *Sorry, SOLI: Good-Bye ILITs?*, J. OF FIN. PLANNING Art. 4 (April 2006) *available at* www.Fiparent.org (last visited Oct. 10, 2008). The violations were; whether or not that insured purchased the policy on his own initiative, whether there was a rebating violation; whether it violated insurable interest laws, and whether it was against public policy. *Id.* at 3.

149. OP. OFF. GEN. COUNSEL (N.Y. Jun. 3, 2003) (regarding Insurable Interest, N.Y. Ins. Law §3205). *See* N.Y. INS. LAW §3205(a)(1)(McKinney Supp. 2003) defining insurable interest as:

- (a) in the case of persons closely related by blood or by law, a substantial interest engendered by love and affection;
- (b) in the case of other persons, a lawful and substantial economic interest in the continued life, health or bodily safety of the person insured, as distinguished from an interest which would arise only by, or would be enhanced in value by, the death, disablement or injury of the insured.

150. N.Y. INS. LAW §3205(b)(2), (b)(4)(McKinney Supp. 2003) provides:

3205(b)(2) prohibits investors or promoters from soliciting consumers to purchase policies with the intent of later assigning them to either institutional or individual third parties but does not adversely affect legitimate secondary market transactions.¹⁵¹ This law combats the circumvention of the New York insurable interest laws. New York took an even stronger stance in 2006. The December 2006 opinion of the Office of the General Counsel banned STOLI contracts entirely as “speculative investments” pursued for the “ultimate benefit of a disinterested third party” who lacks an insurable interest.¹⁵²

Louisiana also specifically addressed STOLI in Louisiana Bulletin No. 06-05.¹⁵³ The Bulletin not only addresses violations of state insurable interest laws but also considers whether such transactions are a potential violation of state anti-rebating laws.¹⁵⁴ Further, the Bulletin provides guidance regarding the types of questions an insurance company may ask when determining whether to issue policies that may involve STOLI arrangements.¹⁵⁵ Questions regarding whether the applicant has been offered cash or other inducement to purchase a life insurance policy; whether the applicant has been offered free insurance; and whether any finance agreements are in place are all seen as legitimate questions.¹⁵⁶ Allowing insurers to ask these questions is important because it establishes

(b)(2) No person shall procure or cause to be procured directly or by assignment or otherwise any contract of insurance upon the person of another unless the benefits under such contract are payable to the person insured or his personal representatives, or to a person having, at the time when such contract is made, an insurable interest in the person insured.

(b)(4) If the beneficiary, assignee or other payee under any contract made in violation of this subsection receives from the insurer any benefits thereunder accruing upon the death, disablement or injury of the person insured, the person insured or his executor or administrator may maintain an action to recover such benefits from the person receiving them

151. *Id.*

152. Gary S. Mogel, *Investor-Initiated life may be in jeopardy*, INVESTMENT NEWS (February 27, 2006).

153. *Id.*; James J. Donelon, Insurance Commissioner, BULLETIN NO. 06-05 (September 5, 2006).

154. “Such arrangements may, depending on the facts, violate some or all of the following Louisiana Insurance Code provisions, or other Louisiana statutes or jurisprudence, including, but not limited to, insurable interest; prohibition on wagering policies; rebating; prohibition on “wet ink” life settlements; premium finance; and usuary.” James J. Donelon, Insurance Commissioner, BULLETIN NO. 06-05 (September 5, 2006).

155. *Id.*

156. *Id.*

a basis for a fraud action by the insurance company and authorizes a rescission of the policy if a misrepresentation was made.¹⁵⁷

Utah's insurance department issued a bulletin stating that STOLI transactions do not comply with the state's insurable interest requirements.¹⁵⁸ Under Utah law, a "person may not knowingly procure, directly, by assignment, or otherwise, an interest in the proceeds of an insurance policy unless that person has or expects to have an insurable interest in the subject of the insurance."¹⁵⁹ The bulletin continues by defining STOLI transactions and noting that the entire transaction will be reviewed to determine whether it complied with insurable interest laws.¹⁶⁰

More recently, Idaho issued a Bulletin addressing "stranger or investor owned life insurance arrangements".¹⁶¹ The stated purpose of the Bulletin is to alert licensees and residents that acquiring life insurance with the intent of "assigning policy benefits to investors" is illegal under Idaho law.¹⁶² The insurance department further notes that formation of a partnership or other joint arrangement which allows investors to circumvent state insurable interest laws by allowing the investor to become a beneficiary also violates Idaho law.¹⁶³ Generally, such arrangements violate insurable interest and state anti-rebate laws.¹⁶⁴ The Bulletin's solution to STOLI requires a review of the transaction by the department of insurance to see if it was designed to circumvent the state's insurable interest laws.¹⁶⁵ The department will examine the entire transaction to

157. Jensen & Leimberg, *supra* note 34, at 115.

158. D. Kent Michie, Utah Insurance Commissioner, BULLETIN 2006-3 (July 10, 2006) available at www.insurance.utah.gov (last visited Oct. 10, 2008).

159. UTAH CODE ANN. 31A-21-104(1)(b)(West 2007).

160. Michie, *supra* note 146. The comment specifically notes the validity and necessity of specific viatical and life settlements but emphasizes that these transactions are separate and distinct and thus will be limited according to Utah law. *Id.*

161. W.W. Deal, Director of the State of Idaho Department of Insurance, BULLETIN No. 07-03 (April 2, 2007).

162. *Id.* The bulletin then goes on to explain the type of transactions they are referring to, stating that a typical arrangement involves, loans in order to pay premiums, assignment of policy to investor after specific period of time. *Id.*

163. *Id.*

164. Rebate laws generally prohibit the use of inducements to purchase insurance. Individual states employ varied approaches. Idaho law specifically prohibits any rebates or inducements greater than fifty dollars if not included in the policy terms... [t]herefore an investor offers to pay premiums, provide financing for the insurance or promises future payment for the policy may violate this law. Deal, *supra* note 146. In reference to insurable interest, Idaho law does allow legitimate assignment regarding key-man insurance and where the irrevocable beneficiary is a charity or religious or educational institution. *Id.*

165. *Id.*

determine the intent of the parties.¹⁶⁶ This includes reviewing the solicitation materials including who initiated the transaction, the terms of any and all written agreements involved, incentives for assignment, promises of future compensation, time between the inception of the policy and the assignment, who pays the premiums, and any other documents or transactions related to the arrangement.¹⁶⁷

The movement of states to either stop liberalizing insurable interest laws or narrow them through the opinions of state attorney generals or insurance departments shows that prohibiting STOLI is required. It also preserves the legitimate secondary market in the process. The many concerns STOLI transactions raise¹⁶⁸ warrant this treatment and parallel treatment in other states that have yet to address the implications of STOLI transactions.

c. NAIC MODEL LAW AND THE STATE LEGISLATIVE RESPONSE

Several organizations have been instrumental in influencing state regulation of the business of insurance. The National Association of Insurance Commissioners is such an organization which frequently promulgates model codes.¹⁶⁹ The NAIC was integral in encouraging states to pass laws regulating viatical settlements. After the creation of its model viatical settlements act, many states passed similar acts, and the same process took place regarding life settlements.¹⁷⁰ In general the NAIC has an interest in regulating these types of transactions in order to create greater uniformity in the law.

166. *Id.*

167. *Id.*

168. *See supra* Part II.

169. The NAIC was created in 1887 and is one of the oldest and largest “organizations of state regulatory officials in the country....it has developed more than 200 model laws to meet the needs of state insurance regulators...It has had a primary goal of creating uniformity in state insurance regulatory laws.” Bruce M. Botelho, Attorney General for the State of Alaska, Letter to State Senator Dave Donely, n.17 (April 22, 1996) (on file with author). Another industry organization that establishes model laws is the National Conference of Insurance Legislators (“NCOIL”). They too have sought to regulate STOLI transactions but have in force a two year moratorium on the sale of such policies rather than the five year moratorium imposed by the NAIC model regulation. This note focuses on the NAIC regulation rather than any upcoming NCOIL regulations because the NAIC regulations do more to prohibit STOLI transactions.

170. Gary S. Mogul, *As Life Settlements gain acceptance, regulators rev up their security*, INVESTMENTNEWS (March 27, 2006) available at www.lisassociation.org (last visited Oct. 10, 2008).

With the emergence and growth of STOLI, the NAIC has revised its viatical and life settlements model act to incorporate and address STOLI concerns.¹⁷¹ The new model act, adopted by the NAIC on June 4, 2007, would make STOLI transactions virtually impossible.¹⁷²

The main objectives of NAIC's revisions are to increase the regulation of the secondary life insurance market in general,¹⁷³ but more importantly to eliminate STOLI arrangements.¹⁷⁴ This is achieved through a five-year moratorium on policy sales after the purchase and issuance of the policy.¹⁷⁵ The moratorium is designed to deter investment in STOLI transactions by reducing investors' rates of return. The exceptions to the moratorium are if the transaction qualifies as a viatical settlement¹⁷⁶, if the transaction

171. Recently, the National Conference of Insurance Legislators ("NCOIL") also issued standards for regulating STOLI. The NCOIL legislation broadens the definition of STOLI classifying those transactions as fraudulent, sets forth new reporting requirements, and increases penalties for those who engage in STOLI. *An Update on Recent Developments Involving Stranger Owned Life Insurance (STOLI)*, *supra* note 103, at 2. The key difference between NCOIL and NAIC regulations is that NCOIL does not call for a five year moratorium of STOLI but rather focuses on regulation and best practices. These are positive steps but because of the numerous adverse public policy consequences including, the ethical and moral implications, as well as economic, elimination of STOLI is more appropriate. Further without the moratorium it is easier for states to manipulate the language of the NCOIL model so that while the state looks like it is curbing the practice of STOLI in actuality it is not. See National Association of Insurance and Financial Advisors, *STOLI Alert*, VOL. 2 ISS. 1 (March 2008) available at www.naifa.org (last visited Oct. 10, 2008); ("In reality, the Kentucky bill [based on the NCOIL model act] guts key provisions of the NCOIL model, rendering it ineffective").

172. *NAIC Adopts Viatical Settlements Model Act Revisions*, National Association of Insurance, News Release (June 2007) available at www.naic.org (last visited Oct. 10, 2008). The adoption of the model act has been a fairly contentious process with those opposed arguing that the model act will negatively and inappropriately limit legitimate life settlement transactions as well as infringe upon an insured's property rights. Jim Connolly, *Proposed 5-Year Ban Remains Sticking Point On Viatical Draft*, NAT'L UNDERWRITER, LIFE & HEALTH 110, 35 (Sept. 18, 2006). These concerns are largely unfounded as the act contains specific exceptions which would allow legitimate life and viatical settlements to occur during the five year moratorium. See *supra* note 176-180 & accompanying text.

173. *New Obstacles to Stranger-Owned Life Insurance Transactions ("SOLI")*, Greenberg Traurig, LLP Special Report (2006) available at www.GTLAW.com (last visited Oct. 10, 2008). The amendments to the model act create additional disclosure requirements for brokers as well as advertising and marketing restrictions and strengthen insurance companies rescission rights. *Id.*

174. *Id.*

175. *Id.*

176. This means if the person is terminally or chronically ill. *Id.*

qualifies as a legitimate life settlement¹⁷⁷, or if the insured's spouse passes away.¹⁷⁸ Further, certain policies may be sold after two years if premiums are paid only with "unencumbered assets", if financing is limited to the cash surrender value of the policy and a recourse loan is utilized, if there is no agreement or understanding regarding the liability of the loan used to purchase the policy¹⁷⁹, or if there has been no evaluation of the insured or the policy for settlement.¹⁸⁰

Under this model, legitimate life and viatical settlements, which are considered beneficial to the secondary life insurance market, are allowed to continue. The prohibition only applies when there has been no change in an insured's circumstances or where premium financing or an agreement regarding the purchase of the policy is utilized.¹⁸¹ Obviously this catches the most basic of transactions but it also catches the most egregious and harmful to those seeking insurance and to the industry.

States have begun to respond by amending their insurance codes, often based upon the NAIC model act. Legislation has been enacted in Indiana, Iowa, Kansas, Maine, Nebraska, North Dakota and West Virginia.¹⁸² North Dakota has adopted the model act put forth by the NAIC.¹⁸³ Indiana's House and Senate adopted House Enrollment Act 1379 which establishes a statutory definition of STOLI and maintains that it is an unlawful

177. Therefore if there is some change in life circumstance like divorce, disability, retirement, or bankruptcy the transaction would be legitimate. *Id.*

178. *Id.* There is also an exception if the policy was issued based upon the insured's conversion rights. *Id.*

179. This includes the investors assuming the loan upon sale. *Id.*

180. *Id.*

181. *Id.*

182. Jim Connolly, *Pace of Anti-STOLI Legislation Picks Up*, NATIONAL UNDERWRITER LIFE & HEALTH (2008) available at www.lifeandhealthinsurancenews.com (last visited Oct. 10, 2008). Indiana has adopted the NCOIL definition of STOLI. *Id.* See also *Indiana Legislation Strong First Step In Battle Against Abuse Of Life Insurance*, ACLI NEWS RELEASE (March 17, 2008) available at www.acli.com (last visited Oct. 10, 2008); *Landmark West Virginia Law Protects Seniors; Leads Way For Rest Of Nation*, INSURANCE NEWSNET (March 13, 2008) available at www.insurancenewsnet.com (last visited Oct. 10, 2008).

183. North Dakota S.B. 2268 was unanimously passed by the North Dakota Senate and closely resembles the NAIC model act with regards to the STOLI amendments. Jim Connolly, *North Dakota Bills Advance*, NAT'L UNDERWRITER LIFE & HEALTH 7 (March 26, 2007). North Dakota was the first state to enact a statute based on the NAIC Model Act. *Missouri Panel Eyes Abusive Life Insurance Transactions*, ACLI PRESS RELEASE (September 2007).

practice.¹⁸⁴ The legislation is awaiting the approval of the Governor.¹⁸⁵ West Virginia has enacted and the Governor has signed into law legislation, S. 704, which establishes a legal definition of STOLI, identifies it as a fraudulent act and establishes a five year ban on the settlement of STOLI policies.¹⁸⁶ Other states either close to enacting STOLI legislation or considering STOLI legislation include Ohio, Oklahoma, Illinois, Connecticut, California, New York, Florida, Arizona, Hawaii, Louisiana, North Carolina, and Rhode Island.¹⁸⁷ STOLI bills failed to pass in Georgia and Massachusetts.¹⁸⁸ No action has been taken to date in Idaho, Utah, Wisconsin, Arkansas, Montana, Nevada, Oregon, and Texas.¹⁸⁹

d. HOW STATES SHOULD RESPOND TO STOLI TRANSACTIONS

Regulating the business of insurance is almost entirely the province of states.¹⁹⁰ This means states have a responsibility to fill the regulatory vacuum that has developed with respect to STOLI transactions. The responses of state insurance departments are the first important step. A legislative or judicial response is necessary to support insurance departments' declarations. In addition to providing greater authority to regulate STOLI, states need to actively enforce laws already in place. Consumers and companies need strong and effective legal remedies in order to counteract the abusive practices of STOLI.

184. *Indiana Legislation Strong First Step in Battle Against Abuse of Life Insurance*, ACLI NEWS RELEASE (March 17, 2008) available at www.acli.com (last visited Oct. 10, 2008).

185. *Id.*

186. West Virginia S. 704 combines features of both the NAIC and NCOIL model acts. *Landmark West Virginia Law Protects Seniors; Leads Way For Rest of Nation*, ACLI News Release (March 13, 2008) available at www.insurancenewsnet.com (last visited Oct. 10, 2008).

187. Jim Connolly, *Pace of Anti-STOLI Legislation Picks Up*, NATIONAL UNDERWRITER LIFE & HEALTH (2008) available at www.lifeandhealthinsurancenews.com (last visited May 14, 2008). Ohio, Oklahoma and North Carolina all track the NAIC model. *Id.* Illinois is considering both the NAIC and the NCOIL models. *Id.* Arizona, Connecticut, California, Hawaii, Louisiana and Rhode Island are all considering the NCOIL model. *Id.* Further, New York is enacting legislation based on neither model and it is unclear what Florida is basing their reforms on. *Id.*

188. *Id.*

189. *Id.*

190. 15 U.S.C. §§ 1011-13 (2008); *Life Partners Inc. v. Morrison et al*, 484 F.3d 284 (4th Cir. 2007).

PART IV: CONCLUSION

STOLI transactions do not create beneficial competitive practices but rather abuse the life insurance market and raise bars to seniors trying to obtain insurance coverage. Unchecked, STOLI has the potential to permanently and negatively alter the life insurance paradigm. It creates dangerous financial and legal risks for purchasers, investors and life insurance companies, and also raises serious ethical concerns. It would be insufficient to ensure that all participants are made aware of the risks so they can make informed judgments. A practice as egregious as STOLI should be eliminated entirely.

The permanent damage caused by STOLI to both the secondary and primary life insurance markets is a major issue. STOLI raises potential solvency issues, increases premiums for those in need of life insurance, and casts doubt on the legitimacy of the industry as a whole. Moreover, states have an interest in protecting vulnerable senior citizens from the misleading promises of free insurance and quick returns.

State legislators and regulators have an “unprecedented opportunity to take a leading role in protecting consumers from a growing national abuse that threatens to undermine the social purpose of life insurance.” Only nineteen states¹⁹¹ have adopted or proposed bills or regulations regarding STOLI, while the remaining states have not enacted any form of regulation for the secondary life insurance market or for STOLI specifically.¹⁹² These states should be enforcing their insurable interest laws and should strongly consider the five-year moratorium promulgated by the NAIC. The moratorium seeks to diminish the rate of return for investors and thereby deter the STOLI scheme. Regardless of the method employed, states should prohibit the use of STOLI transactions. The statutory structure for doing so is already in place in all 50 states and should be fully utilized.

191. *See supra* notes 182-89 and accompanying text. The point remains that a majority of states are not regulating or preventing STOLI. Because STOLI often involves transactions across state lines it is important that all states address the abusive practices of STOLI.

192. David Giust, *Scrutinizing Life Settlement Sales*, *Bank Insurance & Securities Association* (2008) available at http://www.bisanet.org/bism/2008/life_settlements.html (last visited Oct. 10, 2008).

REGIONAL SHORTCOMINGS AND GLOBAL SOLUTIONS: KIDNAP, RANSOM AND INSURANCE IN LATIN AMERICA

Samantha Kenney*

It takes only a few clicks of the mouse while on the internet to realize the face of insurance in America, and much of the Western world, has changed dramatically since its inception. Insurance agencies no longer offer just the traditional auto, health and life insurance policies. Today, certain types of specialty insurance have become increasingly popular and are now available from major insurance companies.¹ With consumers having the option to purchase plans that protect their weddings, household help, college students, “twenty-somethings”, and even their identity from theft,² it seems that insurance can protect anyone from anything so long as they are willing to pay the premium.

As such, it is unsurprising that in today’s increasingly global, and often volatile, world, the demand for a unique specialty insurance to protect against kidnap for ransom has grown.³ With boundaries that once created a marked separation between countries growing more and more obsolete in the business world,⁴ kidnap and ransom insurance (“K & R”) is being purchased by large fortune 500 companies, as well as small to midsized companies, manufacturing and service firms and financial institutions to protect their employees.⁵ This insurance is not limited to companies

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1. Three major insurance companies offering specialty insurance are Lloyds of London, AIG, and Victor O. Schinnerer & Company offer specialty insurance. This can be found on their websites at http://www.lloyds.com/About_Us/What_is_Lloyds/at_a_glance.htm, http://www.aig.com/specialty_20_7402.html, and <http://www.schinnerer.com/index.html> respectively.

2. Insurance Information Institute, Major Types of Specialty Insurance, <http://www.iii.org/individuals/other> (last visited Jan. 24, 2008).

3. Maria O’Brien, *Preparing for the Worst*, LATIN FINANCE, June 2001, at 42.

4. V.A. Tommy, *Managing Risk While Crossing Treacherous Borders*, GULF NEWS, May 24, 2006, <http://archive.gulfnews.com/articles/06/05/24/10042030.html>.

5. Barbara Bowers, *Hostage Situations: Kidnappings for Ransom are on the Rise and Insurers are Selling More Policies to Protect Executives Who Travel in High-Risk Countries*, BEST’S REVIEW, Mar. 2001, at 70, 71.

though; increasingly more often, individuals are even purchasing plans to protect themselves and their families.⁶

Latin America has long held the dubious honor of being the most dangerous area in the world for kidnappings.⁷ Of the countries with the highest risk of kidnapping for ransom or hostage taking, Mexico, Colombia and Brazil all top today's list.⁸ In fact, Colombia has been dubbed "the kidnapping capital of the world"⁹ where kidnapping is more than a crime; it is a business.¹⁰ Specifically troubling in Latin America is the kidnapping activity of the Revolutionary Armed Forces of Colombia (FARC), a rebel group who uses kidnapping as their second largest source of financial support.¹¹ As such, K & R policies are being purchased more frequently; providing an abductee's family the financial means necessary to ensure their loved one's safe and reasonably swift return.¹²

Despite its benefits, K & R insurance has recently come under scrutiny for providing customers with precisely what they have paid for; the assurance that if abducted, their families will be able to pay the ransom demanded and bring them home safe.¹³ Alleging that K & R plans are undermining American counterterrorism policies, it has been suggested that the insurance industry adopt a voluntary no-pay policy, whereby K & R insurance could continue to exist, but without providing reimbursement for any ransoms paid.¹⁴ Instead of reimbursement, the focus of K & R policies under a no payment scheme would be enhanced kidnap prevention training and providing crisis management services.¹⁵ This proposal is intended to

6. *Id.* at 72.

7. *In Latin America, a New Breed of Kidnappers is More Brutal*, USA TODAY, Aug. 14, 2004, available at http://www.usatoday.com/news/world/2004-08-14-samerica-kidnappings_x.htm.

8. V. A. Tommy, *supra* note 4.

9. Susan Hansen, *High Net Worth Families, Kidnapping Risk*, TRUSTS & ESTATES, April 2003, at 35.

10. *Id.*

11. O'Brien, *supra* note 3, at 42.

12. These policies help ensure the return of kidnapping victims by providing the money necessary to pay the demanded ransom. They have a proofed effective because kidnappers' motives are more often than not financially driven. *Id.*

13. Meadow Clendenin, *No Concessions with No Teeth: How Kidnap and Ransom Insurers and Insureds are Undermining U.S. Counterterrorism Policy*, 56 EMORY L. J. 741, 741-42 (2006).

14. *Id.*

15. *Id.* at 743.

bring the insurance industry in line with the U.S. government's "no concessions" stance regarding terrorism.¹⁶

This Comment takes the position that a necessary element of any K & R policy is its ability to reimburse an insured's family or employer for payment of a demanded ransom. While kidnap prevention training and crisis management services are valuable and necessary, absent payment, they are insufficient in the event of abduction. Moreover, if payment reimbursement is removed from K & R policies, these plans will be effectively eliminated. Looking at the situation of the Northrop Grumman employees being held in Colombia,¹⁷ this Comment will demonstrate how the alternatives suggested in a no payment policy would not only be ineffective in preventing kidnappings but instead, would increase barriers between kidnap victims and a safe return home. Additionally, this Comment will demonstrate that, given its international nature, instituting a no payment policy for the entire insurance industry is simply not possible. Instead, an international solution ought to be sought through the United Nations.

Part I of this Comment describes the history of K & R insurance, the general coverage provided by a policy and the history and law governing the American insurance industry. Part II discusses the statistical realities of kidnapping, including data on those groups of individuals most at risk for abduction worldwide and more specifically, within Latin America. Part II also addresses the increased rate of kidnapping in Latin America. Part III discusses how citizens of the most affected Latin American countries are adapting and dealing with this crisis, and Part IV relates the saga of the three defense contractors of Northrop Grumman who have been held hostage in Colombia since 2004.¹⁸

Part IV will also assert how it is the "no concessions" policy of the U.S. and the absence of the ability to make a ransom payment which has kept these men from a safe return. Lastly, Part V discusses the potential alternatives to the proven ineffective domestic "no-concession" approach.

16. *Id.*

17. *See infra* Part IV A. While this Comment was pending for publication, the three Northrop Grumman employees, along with former Columbia presidential candidate Ingrid Betancourt and eleven other hostages were rescued from the FARC. *See Betancourt, U.S. Contractors rescued from FARC*, CNN.COM, July 3, 2008, available at <http://edition.cnn.com/2008/WORLD/americas/07/02/betancourt.colombia/index.html> (last visited Aug. 11, 2008). This was achieved only after the Colombian military secretly infiltrated the group. *Id.*

18. *See infra* Part IV A.

It discusses why the appropriate way to deal with the Latin American situation, an international crisis, is through an international system of accountability and assistance from the United Nations, rather than unilateral American action.

I. THE HISTORY AND COVERAGE OF K & R POLICIES

A. HISTORY OF K & R

Kidnapping is a centuries old crime; a crime historically prolific during times of great social and economic transition.¹⁹ Many countries are currently experiencing this type of social and economic transition.²⁰ Just as the crime of kidnapping is not new, neither are efforts to protect oneself and ensure access to necessary means to pay a ransom. The first K & R policy dates back to 1932²¹ and was offered by Lloyd's of London.²² This specialty insurance was first offered shortly after the highly publicized kidnapping of Charles Lindbergh's baby son.²³

Despite its early entrance on the insurance scene, K & R policies did not achieve prominence until the 1960's when a series of bank executives' wives were kidnapped.²⁴ After that point, the market for K & R insurance exploded and became Lloyd's single most important growth area from the middle of 1970 to the mid-1980s.²⁵ This trend has generally continued. As recently as 2005 80% of Fortune 500 companies had purchased K & R policies.²⁶ While a seemingly untraditional corporate investment, these

19. Hansen, *supra* note 9, at 35.

20. *Id.*

21. *Id.* at 36.

22. Lloyd's is the world's leading insurance market providing specialist insurance services to businesses in over 200 countries and territories. Lloyd's About Us, *available at* http://www.lloyds.com/About_Us/ (last visited July 9, 2008). In 2007, 66 syndicates were underwriting insurance at Lloyd's. *Id.* Lloyd's has long been a pioneer in the insurance industry, beginning in 1688 when it was operated in Edward Lloyd's Coffee House. Lloyd's Chronology, *available at* http://www.lloyds.com/About_Us/History/Chronology.htm (last visited July 8, 2008). Starting with its roots in marine insurance, Lloyd's has grown over 300 years to become the world's leading market for specialty insurance. *Id.*

23. Hansen, *supra* note 9, at 36.

24. Clendenin, *supra* note 13, at 750.

25. *Id.*

26. *Id.* The total of the annual premiums paid for those policies was estimated at more than \$250 million. *Id.* The Lloyd's of London syndicate, Hiscox, held between 60% and 70% of these policies. *Id.* at 751.

policies have become popular for filling the gaps that other, more customary forms of insurance do not cover.²⁷

B. MAIN AREAS OF K & R POLICY COVERAGE

Though Lloyd's of London was the first to offer K & R policies, today, they are just one among many who offer this specialty insurance.²⁸ A standard K & R policy has five main components, four of which encompass reimbursement of money lost from a kidnapping.²⁹ These four reimbursement components are as follows: (1) reimbursement of any ransom paid; (2) reimbursement for expenses related to securing the release of a kidnap victim or resolution of extortion threat;³⁰ (3) reimbursement of expenses relating to securing the release of a detained or hijacked victim; and (4) reimbursement of money lost when being delivered as ransom.³¹ The fifth, non-reimbursement component of a K & R policy is access to

27. *Id.* at 748-49.

28. While many insurers offer K & R plans, the coverage varies greatly from policy to policy. *Id.* at 753. This Comment will be looking at the K & R plan by Victor O. Schinnerer & Company, carried by Great American Insurance Company and underwriting support provided by the Lloyd's of London syndicate Hiscox. Victor O. Schinnerer Policy Highlights, *available at* http://www.schinnerer.com/product_info/kidnap_ransom/k_r_program.html (last visited July 9, 2008). The Schinnerer K & R policy is available for any for profit or non profit organization, including religious organizations and educational institutions. Victor O. Schinnerer Frequently Asked Questions, *available at* http://www.schinnerer.com/product_info/kidnap_ransom/k_r_fa.html (last visited July 9, 2008). It also may be converted to provide coverage for high net worth individuals and families. Elisabeth Eaves, *Most Dangerous Destinations 2007*, FORBES.COM, Feb. 1, 2007, *available at* http://www.forbes.com/travel/2007/01/31/most-dangerous-destinations-forbeslife-ee_0201dangerousdestinations.html (last visited July 9, 2008). Most individual policies purchased will pay for the cost of dealing with a kidnapping, but unlike the corporate plans, do not reimburse the amount of the ransom payment. *What Does Kidnap and Ransom Insurance Cover*, INSURANCE INFORMATION INSTITUTE *available at* <http://www.iii.org/individuals/business/optional/kidnapandransom/> (last visited July 9, 2008).

29. Clendenin, *supra* note 13, at 751-52.

30. Extortion is defined by the Victor O. Schinnerer & Company policy as the following types of threats made in conjunction with a ransom demand: "A threat to kill, injure or abduct, [a] threat to damage property, [a] threat to contaminate products; [a] threat to divulge trade secrets, [a] threat to introduce a computer virus." Victor O. Schinnerer Extortion Highlighted, *available at* http://www.schinnerer.com/product_info/kidnap_ransom/pdfs/extortart.pdf (last visited July 9, 2008).

31. Clendenin, *supra* note 13 at 752-53.

security consultants for preventative measures as well as access to individuals experienced in hostage negotiation, risk management and crisis response in the event of an abduction.³² The “crisis management team” to whom the insured’s family or employer has access to are often consultants with military, intelligence and police backgrounds.³³ Specifically, they have extensive experience dealing with kidnap and extortion situations.³⁴

While the above mentioned are the main components of a K & R policy, plans can be tailored to an individual or company’s specific needs. The options for coverage outside the five main areas are expansive and can cover everything from providing reimbursement of reward money provided to an informant, reimbursement of fees incurred in securing and employing an interpreter,³⁵ and reimbursement of lawyers expenses³⁶ to reimbursement of personal financial loss of a kidnap victim,³⁷ and payment of a victim’s cosmetic surgery for injuries sustained as a result of kidnap.³⁸ These options, along with the varying level of danger posed in different countries and an individual clients’ history with kidnap incidents, cause plan premiums to vary greatly.³⁹ Just as important as the area where the work is being done, the type of work in which a client is engaged can also affect the cost of a K & R policy.⁴⁰

32. *Id.* at 752.

33. See Victor O. Schinnerer Policy Highlights, *supra* note 28. These services are provided by an outside company like the international crisis and response company, Control Risk. See *id.* When handling a case, Control Risk has four main objectives: (1), in the event of a kidnapping, a “safe, timely and secure” victim release, (2) handling extortion within the interests of their client, (3) for business clients, safeguarding the continued business operations and (4) to always act within the law. *Id.*

34. *Id.*

35. Victor O. Schinnerer Extortion Highlighted, *supra* note 30.

36. Clendenin, *supra* note 13, at 752.

37. Victor O. Schinnerer Extortion Highlighted, *supra* note 30.

38. Victor O. Schinnerer Policy Highlights, *supra* note 28.

39. See Clendenin, *supra* note 13, at 753. While the premiums vary dependent upon the policy limit, the area of the world in which an individual is looking to be covered for is of greater consequence. See *id.* For example, a policy with a \$1 million limit can be purchased by some for as little as \$700 a year. Monica Perin, *Kidnapping for Ransom a Rising Risk Overseas*, HOUSTON BUSINESS JOURNAL, (Mar. 4, 2005), available at <http://houston.bizjournals.com/houston/stories/2005/03/07/story5.html> (last visited July 9, 2008). However, for coverage somewhere with as great a risk as Colombia, for the same \$1 million policy limit the premium can be as much as \$20,000 a year. *Id.* This does not mean that only those able to pay a premium in the tens of thousands can afford a K & R policy for higher risk areas around the world. Other corporate K & R policies are offered between \$1,500 and \$5,000 a year for companies in high risk situations. *Id.*

40. See Clendenin, *supra* note 13, at 753.

C. HISTORY OF AMERICAN LAW GOVERNING INSURANCE

American law governing insurance has had a long and complicated history. The greatest difficulty surrounding insurance law has been the struggle between the Federal and State governments as to who should regulate it.⁴¹ Until 1944, insurance regulation was left to the sole discretion of the states, as insurance was not considered “commerce” and thus, was not subject to federal jurisdiction.⁴² This distinction was made largely because insurance was not a tangible good⁴³ and therefore, not commerce. This left insurance regulation to the discretion of states, rather than Congress.⁴⁴

However, in 1944, the case of *United States v. South-Eastern Underwriters Association*, the Supreme Court held that persons engaged in the insurance business are subject to federal regulation since insurance involves the transmission of “money, documents, and communications across dozens of states lines.”⁴⁵ In 1945, with the passage of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011, Congress declared the power of the states to regulate the insurance industry, but retained Federal authority over areas of the insurance industry that were unregulated by the states.⁴⁶ Within 3 years of the passage of the McCarran-Ferguson Act, states enacted similar anti-trust laws to those passed by the Federal Government; allowing them to maintain regulatory control of the insurance industry after July 1, 1948. Consequently, until recently, states have maintained complete control over the insurance regulation.⁴⁷

The most recent action in the struggle to balance state and federal insurance regulation came late in 1999 when President Clinton signed the

41. *Who Regulates Insurance*, Bayland Insurance Group, available at <http://www.baylandinsurance.com/regulatinginsurance.html> (last visited July 9, 2008).

42. Cornell University Law School Insurance Law: An Overview, <http://www.law.cornell.edu/topics/insurance.html> (last visited Jan. 24, 2008).

43. Bayland, *supra* note 41.

44. *Id.*

45. *United States v. South-Eastern Underwriters Ass'n.*, 322 U.S. 533, 549-553 (1944).

46. Cornell, *supra* note 42. Specifically, Congress held that the Sherman Act, the Clayton Act, and the Federal Trade Commission Act are applicable to insurance business to the extent it is unregulated by state law. *Id.*

47. Bayland, *supra* note 41. There are specific Federal statutes that regulate insurance other than 15 U.S.C. § 1011, among them are 15 U.S.C. § 6701 and 18 U.S.C. § 1033 (f). *Id.*

Gramm-Leach-Bliley Financial Services Modernization Act.⁴⁸ This Act was signed into law as a response to the changes and developments in both the marketplace and technology that have blurred the lines demarcating traditional roles of various financial service providers.⁴⁹ The Gramm-Leach-Bliley Act removed then existing distinctions between insurance companies, banks and investment services and as a result, impacted insurance industry regulation.⁵⁰ The probable long term impact of the Act will be greater federal regulation of the insurance industry.⁵¹ However, as the implications of this Act are still being understood and playing out in Washington, navigation of both state and federal insurance statutes still determines whether state or federal law is applicable in a given situation.⁵²

Though state statutes for insurance override most federal laws, some portions of federal law are *always* commanding.⁵³ Therefore, when determining whether state or federal law governs a particular insurance issue, the inquiry ought to be whether the issue is related to the "business of insurance", making state law applicable, or whether the issue relates to issues related to of the insurance industry,⁵⁴ where federal law governs.⁵⁵ The essential point of this analysis is that each issue must be looked at individually to see whether state or federal law applies.⁵⁶ What makes this problematic is that when state law is applicable rather than federal, the same claim could potentially have a different result in every state.⁵⁷

II. WHERE, WHO AND WHY OF KIDNAPPINGS

The world that we live in today is dramatically different than it was just a short time ago. As a result of globalization and easy, cheaper travel,

48. Bayland, *supra* note 41.

49. *Id.*

50. *Id.*

51. *Id.*

52. *Id.*

53. Cornell, *supra* note 42. An example of where portions of federal law are always commanding is federal tax law. *Id.*

54. Some examples of peripheral related issues would be labor, tax or securities issues. *Id.*

55. *Id.*

56. Looking at the applicable laws of every state is the only way to determine whether state or federal law applies. *See generally* Cornell University Law School Law By Topic, available at http://www.law.cornell.edu/topics/state_statutes3.html#insurance (last visited July 9, 2008).

57. *See id.*

business is expanding into regions once thought too risky to work.⁵⁸ This kind of expansion is occurring so as to allow companies to minimize the cost of materials and labor in order to maximize profit margins.⁵⁹ With this explosion of globalization comes the need to evaluate the areas in which companies are moving. Particularly important for a company to consider in selecting an international location is the danger that will result from being in a foreign and often less developed and volatile country. With many companies capitalizing on the absence of import tariffs from fellow NAFTA countries and moving production sites into Latin America, it is necessary to consider that area's epidemic of kidnap for ransom; where the most dangerous countries within Latin America are, who faces the greatest risk of abduction, and why kidnapping is so problematic in these countries.

A. WHERE: THE MOST DANGEROUS PLACES IN THE WORLD

There are many places in the world which American's traveling for both business and pleasure know to be dangerous. The threat of being mugged or murdered while in a foreign country is not something that people often forget when traveling abroad and they often take measures to prevent its occurrence. However, being kidnapped and held for a ransom is not something for which many people plan. This is likely because there is little concern of being kidnapped while traveling within the United States.⁶⁰ Here, kidnappings are few and far between and when they do occur, 95% of all kidnappers are caught and punished.⁶¹ However, in other areas of the world, this is not the case. Those areas where the risk of kidnapping for extortion is the greatest are the regional trouble spots of Southeast Asia,⁶² areas of the former Soviet Union, and Latin America.⁶³

It is this last region where kidnapping has reached a point that the number of abductions are deserving of the term epidemic. Of the known kidnappings worldwide between 2000 and 2004, 73% were in Latin

58. Eaves, *supra* note 28.

59. *Id.*

60. Hansen, *supra* note 9, at 35.

61. Steve Macko, *Kidnapping: A Latin American Growth Industry...*, ENN DAILY INTELLIGENCE REPORT, (April 30, 1997), available at <http://www.emergency.com/latnkdpn.htm>. (last visited July 9, 2008).

62. Specifically, the Philippines has been most problematic area in Southeast Asia. *Id.*

63. Hansen, *supra* note 9, at 35; V.A. Tommy, *supra* note 4.

America.⁶⁴ Despite the dynamic and widely publicized videotaped kidnappings that have recently occurred in Iraq, Latin America has not received the same media attention for what is a more serious problem than the Middle East kidnappings.⁶⁵ In fact, in 2005 that figure continued to increase, up to 75%.⁶⁶

It is estimated that 7,500 kidnappings a year occur in Latin America⁶⁷ and in Colombia and Mexico alone, each year there are between 2,000 and 4,000 kidnappings annually.⁶⁸ While these statistics are individually astounding and terrifying, it is even more disconcerting when the following is considered. The number of annual abductions released is more likely than not significantly lower than the true number of kidnappings.⁶⁹ These numbers are prone to deflation since so few kidnappings are actually reported.⁷⁰ Kidnappings may not be reported for a number of reasons. Mainly because (1) a victim's fear of re-kidnap if they come forward to report the crime and (2) a victim's sensitivity after the trauma they experienced.⁷¹ While Colombia has long held the dubious honor of being the kidnapping capital of the world,⁷² in 2007 Mexico saw an increase in violence and kidnappings that resulted in higher kidnapping rates than Colombia. This caused Mexico to garner the title of ransom capital of the world.⁷³

The situation in Mexico has been getting progressively worse since 1994.⁷⁴ In March of that year, Alfredo Harp Helu, a prominent executive in Mexico's largest financial group and close friend to then President Carlos

64. Victor O. Schinnerer Partnering With Experience, *available at* http://www.schinnerer.com/product_info/kidnap_ransom/pdfs/kbrochure.pdf (last visited July 9, 2008).

65. Hansen, *supra* note 9, at 35.

66. *See In Latin America, a New Breed of Kidnappers is More Brutal*, *supra* note 7.

67. *Id.*

68. Perin, *supra* note 39.

69. *In Latin America, a New Breed of Kidnappers is More Brutal*, *supra* note 7. It is estimated that 1 in 10 kidnappings go unreported. *Id.*

70. *Id.*

71. V.A. Tommy, *supra* note 4.

72. *See* Hansen, *supra* note 9, at 35.

73. Jay Root, *Mexico Crime Continues to Surge*, MCCLATCHY, Sep. 22, 2007, <http://www.mcclatchydc.com/homepage/story/19879.html>. That Mexico surpassed Colombia in kidnappings in 2007 may be a result of not only increased violence in Mexico, but also the spread of kidnapping out of Colombia to neighboring countries such as Ecuador, Brazil and Venezuela. *See* Hansen, *supra* note 9, at 35.

74. Macko, *supra* note 61.

Salina, was kidnapped and released after a ransom was paid.⁷⁵ The \$30 million ransom was paid to the kidnappers and Helu's family announced its payment on television.⁷⁶ This announcement seemed to inspire other kidnappers in Mexico and in April of 1994, another prominent businessman, Angel Losada Moreno, vice president of a Mexican supermarket chain, was abducted and released for a \$50 million ransom.⁷⁷ After 1994, kidnappings in Mexico became more frequent and kidnappers were requesting increasingly higher ransoms.⁷⁸ As a result, kidnapping in Mexico has grown to be more prominent than anywhere else in the world.

B. WHO: MOST COMMON KIDNAPPING VICTIMS

Between 2000 and 2004, the two most common victims for kidnapping were dependents⁷⁹ and business personnel.⁸⁰ These two groups constituted one half of the world's abduction victims.⁸¹ The remaining 50% of victims were made up of non professional employees,⁸² government officials and security forces,⁸³ professionals, including journalists,⁸⁴ ranchers,⁸⁵ project workers, including engineers,⁸⁶ tourists, aid workers, religious staff, and sports and media personalities.⁸⁷ At the start of 2006, dependents and business employees remained the most common victim of kidnapping and abduction of foreign nationals has increased by over 275% since 1996.⁸⁸

75. *Id.*

76. *Id.*

77. *Id.*

78. *See id.*

79. 27% of all kidnappings worldwide were of dependents. Victor O. Schinnerer, *Partnering With Experience*, *supra* note 64.

80. 23% of all kidnappings worldwide were of business personnel. *Id.*

81. *Id.*

82. 14% of all kidnappings worldwide were non professional employees. *Id.*

83. 8% of all kidnappings worldwide were government officials and security forces. *Id.*

84. 6% of all kidnappings worldwide were professionals including journalists. *Id.*

85. 4% of all kidnappings worldwide were ranchers. *Id.*

86. 3% of all kidnappings worldwide were project workers including engineers. *Id.*

87. These groups are among those constituting the "other" category of abduction victims. 15% of all kidnappings worldwide consist of victims that fall into the "other" category. *Id.*

88. *See* Victor O. Schinnerer *Why Kidnap, Ransom and Extortion Coverage*, available at http://www.schinnerer.com/product_info/kidnap_ransom/pdfs/why_kr.pdf (last visited July 9, 2008).

While important, raw statistics can only tell part of the story in identifying those at highest risk for kidnapping within Latin America. When considering who may be a potential victim in Latin America, it is important to account for where the business, and hence a kidnapping, would take place. For example, in Guatemala, where only about 100 people a year are kidnapped, the victims tend to be children of wealthy local or foreign businessmen.⁸⁹ Kidnappers who “do their homework” on their victim, following them and learning their habits, are present everywhere though people with no ties to the area are less likely to be abducted. These kidnappers will patiently investigate potential targets and take husbands, wives, children or the elderly from wealthy citizens in order to garner a large ransom.⁹⁰ In these kidnappings, the victims are carefully chosen, the kidnappers are highly sophisticated and they go to great lengths to get valuable information for selecting their victims.⁹¹ Therefore, tourists, people visiting briefly or those passing through a country generally are not there long enough to fall prey to this kind of abduction.⁹²

Other kidnappings are kidnappings of opportunity; in the Colombian cities of Bogota, Medellin, Cali and Cartagena, abductions in taxis are particularly prolific.⁹³ As are abductions late at night, close to midnight, where a victim is taken and held only long enough to make withdrawals from an ATM on two separate posting days.⁹⁴ Anyone alone late at night could fall victim to this kind of kidnapping.⁹⁵ These abductions have great prominence in the big cities of Brazil, Mexico and Colombia⁹⁶ and even those passing through the country driving an expensive car or drawing attention to themselves for their wealth could be taken, even if only in the country for a few hours.⁹⁷ On the other hand, also in Brazil, it is usually local residents, rather than foreigners, that fall victim to the sequestros relampagos.⁹⁸ As can readily be seen, the type of kidnappings most

89. Macko, *supra* note 61.

90. Jennifer Litz, *Kidnapped in Mexico*, SAN ANGELO LIVE, (June 3, 2007), available at <http://www.sanangelolive.com/node/491> (last visited July 9, 2008).

91. *Id.*

92. *Id.*

93. O'Brien, *supra* note 3, at 42.

94. Litz, *supra* note 90.

95. While anyone is potentially a victim of this kind of kidnapping, executives visiting the area are more vulnerable to these kinds of random, opportunistic kidnappings. O'Brien, *supra* note 3, at 42.

96. *Id.*

97. Litz, *supra* note 90.

98. Sequestros relampagos are “lightning kidnappings”. O'Brien, *supra* note 3, at 42.

prominent in a given area will influence those most at risk for becoming a victim of abduction.

C. WHY: KIDNAPPING FOR PROFIT

Kidnapping in Latin America is a business.⁹⁹ Like any business, individuals may have different way of accomplishing their work, but their ends are ultimately the same: to make as great a profit as possible. If nothing else, kidnapping for profit is certainly profitable in Latin America. Whether it is the secuestro al paso¹⁰⁰ which are increasing all over Latin America,¹⁰¹ sequestros relampagos which are particularly prolific in Brazil and Colombia,¹⁰² cross boarder kidnappings, where one group kidnaps a victim and then sells them to another group,¹⁰³ virtual kidnappings,¹⁰⁴ or a more traditional kidnap for ransom, where an individual is kidnapped by one group and held by them until they receive the ransom they desire, kidnappers are making huge profits.¹⁰⁵

A combination of factors has led to the current kidnapping crisis overtaking Latin America. Drastic social change and an increase in the economic split between the rich and the poor have both contributed to the growing problem.¹⁰⁶ As discussed, a recent increase in violence and crime

99. *In Latin America, a New Breed of Kidnappers is More Brutal*, *supra* note 7.

100. Secuestro el paso are “express kidnappings” where the victim is abducted and held long enough to be taken to an automatic teller machine where they are instructed to empty their bank account. O’Brien, *supra* note 3, at 42. After emptying their accounts to their kidnappers, they are released. *Id.*

101. Though increasing all over Latin America, the majority of these kidnappings occur in the big cities of Brazil, Colombia and Mexico. *Id.*

102. *Id.*

103. Bowers, *supra* note 5, at 72. This particular type of abduction is illustrative of the “business” like nature of kidnappings in Latin America. Some kidnappers have taken on a division of labor concept that has long been successful in business. *Id.* In this division of labor, one group skilled in staking out a victim does just that, while another group does the actual kidnapping. *Id.* Then finally, another group altogether holds the victim and negotiates ransom. *Id.*

104. Virtual kidnapping occurs when a caller demands money from someone for the promise that they will not be kidnapped. Anna Cearley, *Kidnap Fears Causing Some to Leave Tijuana*, UNION-TRIBUNE, (May 21, 2005), available at <http://www.signonsandiego.com/news/mexico/tijuana/20050521-9999-1n21kidnap.html> (last visited July 9, 2008).

105. See Schinnerer Kidnap, Ransom and Extortion Protection Insurance, http://www.schinnerer.com/product_info/kidnap_ransom/pdfs/pol_highlights.pdf (last visited June 15, 2008).

106. See V.A. Tommy, *supra* note 4; Macko, *supra* note 61.

can be tied to the present surge in kidnapping in Mexico,¹⁰⁷ while in Colombia, the history of socio-political factors that have made kidnapping for ransom problematic for so long are still present. With many victims refusing to cooperate with the local police, few suspects are ever being caught¹⁰⁸ and weak, inefficient and corrupt law enforcement in these areas¹⁰⁹ make Latin America a particularly attractive niche for the kidnap for ransom industry.

The United States also bears some responsibility for the surge of kidnappings in Latin America. In 2000, former President Clinton signed into law Plan Colombia; a \$6.7 billion program set to receive \$1.7 billion in U.S. aid¹¹⁰ intending to change the face of Colombia.¹¹¹ Originally called the Marshall Plan for Colombia,¹¹² the goals of Plan Colombia were simple; support the peace process with FARC (who make up the largest and oldest rebel group within Colombia), reactivate the Colombian economy, reform the Colombian judicial system, increase respect for human rights and reduce the drug market by fifty percent.¹¹³ While all the objectives of Plan Colombia seem worthwhile, it was the promise to reduce cocaine trafficking to the United States by fifty percent over five years that led the plan to receive the necessary congressional support for passage.¹¹⁴

By 2005, however, Plan Colombia had racked up \$10.6 billion in aid, \$3 billion over the stated budget, and achieved none of its stated goals.¹¹⁵ Analysis showed an increase in both cocaine trafficking and use., as well as

107. Jay Root, *Mexico Crime Continues to Surge*, McCLATCHY, Sep. 22, 2007, <http://www.mcclatchydc.com/homepage/story/19879.html>.

108. Macko, *supra* note 62.

109. *Id.*

110. The United States agreed to provide \$1.7 billion to the project, so long as it had the power to determine how the money was spent. J. Thomas Ordóñez, *Plan Colombia*, CENTER FOR LATIN AMERICAN STUDIES, UC BERKELEY (October 23, 2006), <http://www.clas.berkeley.edu:7001/Events/fall2006/10-23-06-coronell/ordonez.html>. Another \$1 billion was provided by the European Union and the remaining \$4 billion was to be borrowed by Colombia from the Inter-American Development Bank as well as the World Bank. *Id.*

111. *See* Bowers, *supra* note 5, at 74.

112. Ordóñez, *supra* note 110.

113. *Id.*

114. DANIEL CORONELL, PLAN COLOMBIA: COCA MOVES TO THE RIGHT, <http://socrates.berkeley.edu/7001/Publications/newsletters/Fall2006/CLASFall2006-Coronell.pdf> (last visited June 15, 2008).

115. *Id.*

a decrease in its street price¹¹⁶ translating into more, cheaper cocaine on American streets.¹¹⁷ As of 2007, the amount of cocaine trafficked between Colombia and the U.S. has continued to increase.¹¹⁸ Despite receiving some of the highest amounts of financial aid from the United States government, third only to the Middle East and Afghanistan,¹¹⁹ Plan Colombia seems to have thus far, failed on all fronts.¹²⁰ While Congress has recently taken steps towards improving where the plan has failed,¹²¹ until such improvements are put in place and proven effective, Colombia, Latin America and ultimately the rest of the world, are left to deal with the consequences of its failure.

By instituting Plan Colombia, the United States has aided in causing economic upheaval in Colombia.¹²² This has led to major unanticipated side effects. One unanticipated side effect of Plan Colombia is the marked increase in kidnappings.¹²³ It would be easy to think that Plan Colombia only had an impact on its target country of Colombia. However, the effects of the plan can be seen all around Latin America. It is particularly notable with the increase of kidnappings in Colombia's neighboring Latin American countries of Ecuador, Panama and Venezuela.¹²⁴

Another unanticipated effect of Plan Colombia is that as large numbers of Colombian citizens have fled the country, they export crimes.¹²⁵ This phenomenon is known as the Ecuador effect¹²⁶ and is just another way in which the plan's negative effects can be seen around Latin America. Additionally, it is estimated that the FARC makes between \$250 and \$300 million each year between protecting and promoting the illegal drug

116. *Id.*

117. *See id.*

118. Stephen Heidt, *Keep the Freeze on Colombia*, FOREIGN POLICY IN FOCUS, June 20, 2007, <http://www.fpif.org/fpiftxt/4316>.

119. Marcela Sanchez, *Rethinking 'Plan Colombia': U.S. Aid Should Focus on Getting Justice Done*, WASHINGTONPOST.COM, Mar. 16, 2007, <http://www.washingtonpost.com/wp-dyn/content/article/2007/03/15/AR2007031501555.html> (last visited June 15, 2008).

120. CORONELL, *supra* note 114

121. June 5, 2007, the House Appropriations Committee released the 2008 draft foreign aid budget that would make significant changes to President Bush's request to merely provide Colombia with continued military assistance. Heidt, *supra* note 118.

122. CORONELL, *supra* note 114.

123. *See supra* Part II C.

124. *See Bowers, supra* note 5, at 74.

125. *Id.*

126. *Id.*

industry and collecting ransoms from kidnappings.¹²⁷ Therefore, by interrupting the FARC's main source of revenue, drugs, Plan Colombia has likely been responsible for the increase in the FARC's kidnap for ransom.¹²⁸ While increased kidnappings may have been an unanticipated side effect of Plan Colombia, the United States failure to take any action to mitigate this negative and dangerous consequence is short sighted and irresponsible.

These factors collectively, coupled with the unavoidable fact that kidnapping is a relatively safe crime to commit in Latin America,¹²⁹ provide some insight as to why kidnap for ransom has become so widespread in Brazil, Colombia, Mexico and the rest of Latin America. It also helps shed some light on America's shared responsibility for the increase in kidnap for ransom in Latin America; that despite setting out with good intentions, American dictation of policy in other parts of the world does not assure improvement.

III. LATIN AMERICAN OPTIONS

A. DEALING WITH THE KIDNAPPINGS: LOCAL PERSPECTIVES

With the kidnapping industry netting hundreds of millions of dollars each year, criminals once engaged in Latin America's more petty crimes, such as drug smuggling or car theft, have begun to shift their focus.¹³⁰ Seeing huge ransoms paid, coupled with little success for prosecutors seeking kidnappings conviction, these criminals have started to move into what they see as a career with less risk and more reward.¹³¹ While American businesspeople have been targeted for kidnapping, at least within Mexico, many kidnapping groups seem to avoid such foreigners.¹³² In Mexico, for example, only 1 in 10 kidnappings are estimated to be reported each year,¹³³ the effect on locals is undeniable.

127. Columbia's Civil War Revolutionary Armed Forces of Columbia, *available at* <http://cocaine.org/colombia/farc.html> (last visited Aug. 15, 2008).

128. *See id.*

129. Macko, *supra* note 61.

130. Victor O. Schinnerer Kidnap, *supra* note 105; Cearley, *supra* note 104.

131. Victor O. Schinnerer Kidnap, *supra* note 105.

132. Diane Lindquest & Anna Cearley, *U.S. Exec Abducted in Tijuana*, UNION-TRIBUNE, Apr. 7, 2006, <http://www.signonsandiego.com/news/mexico/tijuana/20060407-9999-7m7kidnap.html>. It is speculated that this may be a result of the logistical challenges posed by an international transaction as well as the risk of attention. *Id.*

133. Victor O. Schinnerer Kidnap, *supra* note 105.

While wealthy Americans and corporations have turned to the insurance industry for protection, their counter parts in Latin America have taken a more conventional approach. Guarded by security, they move in armored cars, rarely traveling anywhere other than to and from work because the risk of going to or being elsewhere is just too great.¹³⁴ For those daring enough to travel outside the armored fortresses equipped with expensive security systems they call home, security guards are an indispensable part of their lives.¹³⁵ They stand watch outside restaurants and private schools, giving the appearance of protection for those whom they are protecting.¹³⁶ They provide a sense of safety in Latin America to those whose lives have come to be built around fear,¹³⁷ and a legitimate fear at that.

However, the presence of these guards, reminiscent in appearance to the United States Secret Service,¹³⁸ comes neither cheaply nor with any assurances. With the bare minimum security measures for a company's vice president coming to about \$80,000 in the first year,¹³⁹ and the cost of armoring a sport utility vehicle being about \$70,000,¹⁴⁰ it is easy to see why only the very rich are able to afford the luxuries of such protection. Even when these security measures are in place, safety is not assured. A notable instance of this was in August of 1996 when Mamoru Konno, Vice President of Sanyo Video Components, was kidnapped in Tijuana, Mexico surrounded by employees at a company picnic and baseball game.¹⁴¹ While Latin America's wealthiest citizens are able try and hide behind the protection their money provides, kidnappers are turning to those citizens in Latin America's middle class and as a result, treating victims more brutally.¹⁴²

The effect of these actions against Latin America's citizens is that the people are calling for government action.¹⁴³ Taking to the streets, they are demanding their presidents do something to stop these brutal abductions, though realistically, in the short term, there is little the government can

134. *Id.*

135. *Id.*

136. *Id.*

137. *Id.*

138. *In Latin America, a New Breed of Kidnappers is More Brutal*, *supra* note 7.

139. *Id.*

140. Cearley, *supra* note 104.

141. Lindquest & Cearley, *supra* note 132.

142. *In Latin America, a New Breed of Kidnappers is More Brutal*, *supra* note 7.

143. *Id.*

do.¹⁴⁴ As stated before, kidnapping in Latin America is a business.¹⁴⁵ Just as with any other industry netting millions of dollars each year, the business of kidnap for ransom will continue to thrive until it is no longer profitable.¹⁴⁶

With governments unwilling and, truthfully, unable to protect its citizens, many of the middle class living in Latin America are left with only two choices; stay in the country they have known their entire life and take their chances at being abducted or killed, or be a “refugee from fear”¹⁴⁷ and start a new life in the safety of America. Those families opting to move to the United States generally have dual citizenship or achieve United States residency status through family or marriage.¹⁴⁸ But for those unable to meet the requirements to cross the border, the remaining options are limited. Generally, they have little choice, but to remain in their home country. As kidnapping increasingly affects the middle class, rather than just the wealthy, growing numbers of families are desperately trying to emigrate.¹⁴⁹

This trend has been noted by both United States law enforcement and observers of crime trends, as well as real estate agents.¹⁵⁰ Agents in San Diego County claim to be seeing more clients from Tijuana and in affluent Tijuana neighborhoods, more houses seem to be for sale.¹⁵¹ Moreover, real estate agents are capitalizing on this market, traveling to countries such as Colombia, Venezuela and Mexico to sell properties located in Miami, Florida,¹⁵² and making it that much easier for those inclined to leave Latin America for the United States to have their lives established here as soon as they arrive. For Latin American citizens without the means to procure armored vehicles and a private force of security guards, leaving the country has become the best and most common course of action. These “refugees from fear” are clear examples that preventative measures can only take you so far before more drastic steps must be taken in order to afford one true protection from abduction.

144. *Id.*

145. *Id.*

146. *Id.*

147. Cearley, *supra* note 105.

148. *Id.*

149. *Id.*

150. *Id.*

151. *Id.*

152. *In Latin America, a New Breed of Kidnappers is More Brutal*, *supra* note 7.

IV. “NO CONCESSIONS”: POLICY ON PAPER ONLY

Like many K & R insurance plans the Schinnerer plan, one of the most comprehensive of its kind, covers more than just the individual insured.¹⁵³ Included under the plan are all directors, officers and employees of the assured, relatives¹⁵⁴ of the insured, individuals who work or reside in the insured's household, guests in the insured's household, guests and customers of the assured either on their premises or during transport and the individual negotiating and/or delivering a ransom.¹⁵⁵ However, despite this extensive coverage, government employees cannot be covered under such a plan.¹⁵⁶ In fact, governmental institutions are specifically noted as being ineligible for coverage.¹⁵⁷

That K & R policies specifically preclude governmental institutions from taking out plans and covering their employees seems irrelevant, as most plans providing financial assistance to the insured do so in the form of reimbursement. In order to be reimbursed, the initial payment must be made and since the government has been unwilling to make payment for any abductees, reimbursement would be unnecessary. As reimbursement is one of the most important features of an effective K & R plan, if government institutions were permitted to purchase and carry K & R insurance, it would be unlikely any government institution would find it worth the price. This isn't to say however, that the government has not been using other means at its disposal to undermine its own “no concessions” policy.

A. NORTHROP GRUMMAN EMPLOYEES ABDUCTED IN COLOMBIA

While abduction of government officials accounts for less than eight percent of all abductions worldwide,¹⁵⁸ there are obviously situations where K & R plans would be most beneficial to those employed by governmental institutions and private corporations simultaneously. This point is most

153. Eaves, *supra* note 28.

154. *Relative* is broadly defined and includes domestic partners, fiancées, and foster children. Victor O. Schinnerer Kidnap, *supra* note 105.

155. *Id.*

156. *See id.*

157. *Id.*

158. Victor O. Schinnerer, *supra* note 64. While 8% of kidnappings worldwide is the estimate for government officials, that number includes security forces, therefore the actual percentage of abductions that are government officials is somewhere less than 8%. *Id.*

readily illustrated by the kidnapped Northrop Grumman employees being held hostage in Colombia by members of the FARC.

Thomas Howe, Keith Stansell and Marc Gonsalves are three American citizens employed by the Los Angeles based Northrop Grumman Corporation.¹⁵⁹ Northrop Grumman is the fifth biggest multinational defense corporation in the United States and has been involved with the cocaine eradication missions in Colombia.¹⁶⁰ In 2003, while in a small airplane doing drug surveillance over a rural Colombian jungle, these three Americans were shot down and captured by the FARC.¹⁶¹ Since their abduction, little progress has been made towards achieving the safe return of the three men.¹⁶² This is because the FARC is designated as a terrorist group by the United States government and hiding behind their “no negotiations with terrorists” policy, the government has yet to secure their release.¹⁶³ If these men were just employees of a private corporation, they would likely already be free.¹⁶⁴ It is however, the fact that they are government contractors and it is a direct result of the governments refusal to negotiate with the FARC which has kept these three men imprisoned for over 4 years.¹⁶⁵

The “no negotiations with terrorists” is the very same justification given by some as to why insurance companies ought to adopt a voluntary no payment scheme for K & R policies.¹⁶⁶ The allegations are that by meeting the ransom demands of terrorists, American companies are undermining United States public policy.¹⁶⁷ However, the situation of Thomas Howe, Keith Stansell and Marc Gonsalves seems to clearly demonstrate that the “no negotiations” stance does little more than reinforce that abducted individuals will be held indefinitely by groups like the FARC until they are paid.

159. *Heidt, supra* note 118.

160. Max Jourdan, *Private War: Protecting People or Profit* (BBC Two (UK) radio broadcast Dec. 14, 2004), (transcript available at http://news.bbc.co.uk/1/hi/programmes/this_world/4079691.stm).

161. *Heidt, supra* note 118.

162. Anderson Cooper Blog 360° (June 7, 2007), <http://www.cnn.com/CNN/Programs/anderson.cooper.360/blog/2007/06/key-moment-nears-for-three-american.html> (last visited June 20, 2008).

163. *Id.*

164. *Interview with Joe Fender* (ABC 7 KMGH- CO radio broadcast Aug. 27, 2007), (transcript at WL 16762299).

165. *Id.*

166. Clendenin, *supra* note 13, at 741-42.

167. *Id.*

Recently, the ineffectiveness of the “no negotiations” approach in the Colombian situation seems to have reached its peak and come to the attention of those in the government. In July of 2007, the United States Justice Department made a move in direct contrast with the “no negotiations” policy in an attempt to get Howe, Stansell and Gonsalves home.¹⁶⁸ The Justice Department offered the FARC leniency in the sentencing of Ricardo Palmera, an influential member of the FARC who was convicted in federal court of helping in the three men’s kidnapping in exchange for his release.¹⁶⁹ The men still remain held captive in Colombia.

This recent action by the Justice Department is an indication that America’s “no concessions” stance in Colombia is not as inflexible as initially thought. As such, to say that reimbursement for ransom payments by insurers to individuals holding K & R policies is contrary to American policy, is misleading and untrue. The payment of ransom by a private corporation cannot be held out as contrary to an American governmental policy when the government itself is not consistent with that policy. The government seems to have recognized that in order to assure the safe return of the abductees, they will have to give into the demands of the FARC somehow; hence the offer for leniency. An offer for leniency to a prisoner in exchange for a kidnap victim’s release is, however, a luxury to which the government is privileged but private corporations are not.

Where the government can offer leniency, the only weapon at an individual or private corporation’s disposal to get kidnap victims back is payment of the ransom demanded. A non payment scheme would emulate hundreds of times over the scenario of the Northrop Grumman employees. Moreover, to hold private corporations to a higher standard, regarding the government policy, than the government holds itself to is hypocritical and unjustified.

B. SHORTCOMINGS OF A NO PAYMENT SCHEME

America has yet to find an adequate and effective solution to the kidnappings epidemic in Latin America. It is sheer American arrogance to believe that if the United States insurance companies instituted a voluntary no payment policy in kidnap for ransom situations that kidnappings in

168. *A Convicted Colombian Rebel Leader is Offered Leniency as Part of Efforts to Free Three American Hostages*, SOUTH FLORIDA SUN SENTINEL, July 16, 2007, at 22A, available at 2007 WL 13526075.

169. *Id.*

Latin America and around the world would decrease, or even stop. Any domestic insurance regulation by the United States has no authority over the insurance industry in other countries. As such, insurance companies in these other countries will still be selling K & R policies to corporations and businesspeople, all the while repaying the ransoms the United States insurance industry will not. Absent a voluntary no payment agreement from every insurance company in the world that provides K & R policies, the end result of such a scheme would be to put American citizens at greater risk.

Further, kidnap victims are 4 times more likely to be killed by their abductors when they are uninsured than when insured.¹⁷⁰ Partially, this is because insured victims have the benefits of professionals who know how to handle the abduction properly.¹⁷¹ The benefit of these crisis management professionals is that, in handling the abduction, they do not make the same fatal mistakes that relatives of an uninsured victim tend to make.¹⁷² While this seems to lend support to the supposition that a voluntary no payment policy would be effective, as the professional support a K & R policy can provide is often highly effective, there are additional factors that warrant consideration in this situation.

First, as many K & R policies provide crisis management services as well as reimbursement for ransoms paid,¹⁷³ it must also be considered that these numbers reflect a decrease in the likelihood of a victim being killed when a ransom is paid, as opposed to not paid. Up until 2001, the killing of kidnap victims was relatively rare.¹⁷⁴ However, when seven oil workers were taken in the northeast Amazon region of Ecuador and one was killed after the deadline for payment expired,¹⁷⁵ this seemed to be the beginning of an increasingly violent breed of kidnappers.¹⁷⁶ This breed of kidnapper is the kind that will hold oil workers abducted from Colombia in Guerrilla hideouts for years, rape women after taking them from shopping mall parking lots in Brazil, torture businessmen in Argentina while negotiating a multimillion dollar ransom and return children taken in Mexico one finger at a time to their parents as they await the meeting of their demands.¹⁷⁷

170. Macko, *supra* note 61.

171. *Id.*

172. *Id.*

173. *Id.*

174. O'Brien, *supra* note 3, at 42.

175. *Id.*

176. *In Latin America, a New Breed of Kidnappers is More Brutal*, *supra* note 7.

177. *Id.*

This is also the kind of kidnapper that, if their demands are not met, will simply kill an abducted victim and keep taking others until they get paid.

A no payment policy will put American business people at greater risk because their families may lack the means necessary to secure their release.¹⁷⁸ In America in 2007, seventy percent of Americans held mortgages on the homes they lived in,¹⁷⁹ and the average household carried close to \$8,500 in credit card debt.¹⁸⁰ If the average American is taken while out of the country on business, there is a good chance his family will not have the means to obtain the ransom without liquidating their life. Even then, there is a chance that an abductee's family will still lack the necessary funds, as ransoms have in the past been reported to be as high as over one hundred million dollars.¹⁸¹ And increasingly often, lack of payment translates out into loss of life.

Because of the secret nature of K & R insurance,¹⁸² foreign businesspeople in Latin America are not taken because it is known that they have K & R policies.¹⁸³ In fact, many, if not most, abductees do not even know that there is a K & R policy in place for them.¹⁸⁴ This is because it is a fundamental condition of most policies that its existence be kept confidential and a policy can be voided if this is breached.¹⁸⁵ Rather, individuals are taken because, as a fact of life, people will pay whatever they have to in order to get their family member back.

Kidnappers in Latin America do not care if American law suggests an insurance company not pay reimbursement. What they know is how to run their business; they know if they send the fingers of someone's husband, wife or child to them, they will do anything to get them back. All a K&R

178. This point is clearly illustrated in the case of *Hargrove v. Underwriters at Lloyd's*, London, where the family of Thomas Hargrove, an American employee of a company in Colombia kidnapped by the FARC, wanted to pay the ransom demanded by the FARC but could not afford to pay the multi-million dollar ransom. Clendenin, *supra* note 13, at 766. While Thomas Hargrove was eventually released by the FARC, it was only after 11 months in captivity *in addition* to two ransom payments by his family totaling \$250,000. *Id.* at 767.

179. Credit Card Debt Statistics, MONEY-ZINE (2007) <http://www.money-zine.com/Financial-Planning/Debt-Consolidation/Credit-Card-Debt-Statistics/> (last visited June 20, 2008).

180. *Id.*

181. Victor O. Schinnerer *Why Kidnap*, *supra* note 88.

182. *See* O'Brien, *supra* note 3, at 42.

183. *See* Hiscox Frequently Asked Questions, HISCOX ASM, <http://www.hiscox.com/hiscox-asm/41.html> (last visited June 20, 2008).

184. O'Brien, *supra* note 3, at 42.

185. *Hiscox*, *supra* note 183.

policy does is ensure that a family not lose everything of value they have in trying to get back the one thing they value most.¹⁸⁶

Secondly, it is necessary to consider the premiums paid for these plans. About fifty percent of the world's K & R policies specifically cover Latin America,¹⁸⁷ and depending on the risk of the country where coverage is provided, plan premiums vary greatly.¹⁸⁸ For example, the annual premium for a family of 5 ranges between \$18,000 to \$30,000 for a \$1 million policy.¹⁸⁹ For a \$5 million policy, the premium would be about \$70,000.¹⁹⁰ When companies¹⁹¹ pay out such high premiums, they expect results. If a company pays for a K & R policy that only provides prevention training and access to security experts in the event of an abduction,¹⁹² the need for the insurance itself is eliminated.

Rather than pay out, conservatively, \$25,000 a year for a policy with a \$1 million premium covering an executive living and working in Colombia, the company would be in a better position to save that money and in the event an abduction takes place, hire the same security experts the insurance policy would provide.¹⁹³ By doing this, the company would pay only for service when it was needed rather than pay out hundreds of thousands, even millions, of dollars in premiums over the years.¹⁹⁴ While paying such high

186. *See id.*

187. Macko, *supra* note 61.

188. *Id.*

189. *Id.* The premium of a \$1 million policy would be lower somewhere like Brazil, where the premium for that policy would be only about \$9,000 - \$10,000. *Id.* By contrast, the same plan would be much higher in Colombia. *Id.*

190. *Id.*

191. Companies that are wealthy enough to afford a high end K & R plan with a premium in the tens of thousands of dollars.

192. Macko, *supra* note 61.

193. The three security companies used by the top K & R insurers are Kroll Associates, Ackerman Group and Control Risks Group. *Id.* These security companies can all be readily found on the internet at their websites, available at <http://www.kroll.com>; <http://www.ackermangroup.com>, and <http://www.control-risks.com>, respectively.

194. Under the Schinnerer policy, as representative of K & R policies, once a company receives notification of an abduction, the company then contacts the crisis management company. Victor O. Schinnerer Extortion Highlighted, *supra* note 30. A crisis management team has 4 main objectives; the safe, timely and secure release of the victim, the correct handling in the interest of the client, of extortion, safeguard the continued operations of a client, and to act within the law at all times. *Id.* To achieve these goals they work with management to develop a strategy and tactical options as well as using the company's database and research for support. *Id.* Also, in the even that the story becomes public, the crisis management team may act as a media liaison. *Id.* It is clear that a crisis management team provides everything that would still be permitted under a non payment scheme, as the

premiums over time might be worth it to a company who will be reimbursed for any ransoms paid out, from a financial perspective, it makes much more sense to, rather than pay premiums, to use that money to pay a ransom the company would have to pay out on its own anyway. Additionally, the prevention training which is emphasized by the non payment scheme¹⁹⁵ could be provided in the same manner by these private companies; on an as needed basis. The voluntary no payment scheme is effectively a complete elimination of K & R policies.

V. AVENUES FOR CHANGE

Having determined that a voluntary non-payment scheme is an impractical, and potentially dangerous approach to take in an attempt to improve the kidnapping situation in Latin America, the question becomes what is the appropriate avenue to make the necessary changes. While the American infrastructure provides a few different options, none are particularly suited for this issue and the only way in which Latin America will make any kind of meaningful change is to deal with the underlying issues on an international scale.

A. US COURT INVOLVEMENT

The American court system has litigated issues arising from K & R policies in the past; most notably in *Curtis v. Beatrice Foods*¹⁹⁶ and more recently in *Hargrove v. Underwriters at Lloyd's London*.¹⁹⁷ It has been claimed that the court's decision in *Beatrice Foods* stands for the supposition that in general, employees do not have a duty to rescue employees who have been abducted that were warned they may be a target of kidnapping.¹⁹⁸ That ruling has been taken to say¹⁹⁹ that because of extensive media coverage on international kidnappings in areas like Iraq and Colombia, it is unreasonable for Americans to claim they are unaware

only link in the abduction process for the insurance company the reimbursement of costs and fees associated with abduction, including payment of ransom. *See id.*

195. Clendenin, *supra* note 13, at 773-774.

196. 481 F. Supp. 1275, 1289 (S.D.N.Y. 1980).

197. 937 F. Supp. 595 (S.D. Tex. 1996).

198. Clendenin, *supra* note 13, at 768-69.

199. This case has not been interpreted by the Court since it was decided and the 1980 ruling is still the controlling decision.

of kidnapping risks and as such, employers have no duty to rescue them if abducted.²⁰⁰

However, in the *Beatrice Foods* case, Curtis had been personally warned by the U.S. Embassy that he might be at risk of kidnapping after his picture was obtained from an underworld figure.²⁰¹ Though Curtis attended a security briefing with Control Risks and another arranged by the State Department's Office to Combat Terrorism, he still remained in the country and made none of the suggested changes to his behavior.²⁰² The only action he took to change his routine, predictable behavior and to increase security was investigatory.²⁰³ Analogizing the situation of Curtis, who had extensive warning of his particular personal risk of kidnapping and still failed to take any meaningful action, to the general knowledge possessed by Americans that certain areas of the world pose a greater risk of kidnapping, is to stretch the *Beatrice Foods* decision beyond its practical limit.

Moreover, to imply that a corporation only pays a ransom because they fear litigation from a victim's family if that person is killed or injured, is to appeal to the lowest common denominator. This assumes the worst of multinational corporations; that they would choose not to pay a ransom for financial reasons. It is not unreasonable to believe that a corporation would go to great lengths to secure the safe return of their employee because they do not want to see anything happen to them.²⁰⁴ Or, to take a more selfish, self serving approach to their actions, it is not unreasonable to think that a corporation would pay out a ransom to avoid negative publicity or to deter future employees from being willing to take overseas positions.

In essence, the courts have been involved with K & R policies in the past but only in the role that they were meant to fill; interpretation of the law. Any action by the courts to limit the scope or application of K & R policies would amount to judicial activism and be an improper exercise of their power. Since there is no law regarding K & R policy repayment (or non repayment), there is nothing for the courts to interpret. Therefore, until

200. Clendenin, *supra* note 13, at 770.

201. *Curtis v. Beatrice Foods*, 481 F. Supp. 1275, 1280-81 (S.D.N.Y. 1980).

202. *Id.* at 1280.

203. *Id.*

204. Particularly this was seen in the *Beatrice Foods* case. Given that Curtis had clear personal knowledge he was a target for kidnapping, the court states "Faced with a staggering demand for \$5 million, Beatrice could have washed its hands of the whole affair without incurring any legal liability. However, it instead took the conscientious course of hiring a firm it knew to have dealt with kidnap situations previously to master-mind the negotiations." *Id.* at 1293.

legislative action is taken, the courts do not have a role in the modification of K & R insurance coverage. Moreover, a voluntary non payment scheme is not legislative action; it creates no law for the court to interpret. This lends further weight to the futility of the adoption of a voluntary scheme, as any insurance company who chooses to reimburse the payment a ransom could not be brought into court for violation.

B. LEGISLATIVE ACTION

As established above, a necessary precursor to a court response to the payment of ransom for those taken in Latin America is American legislative action. However, previous attempts to curb kidnappings through legislative action by both the United States and Colombia have proven ineffective.²⁰⁵ Colombia's failed Anti-Abduction Act of 1993 and the United States' Patriot Act and Hostage Taking Act of 1984 illustrate the many difficulties of a legislative solution to this problem.²⁰⁶

Moreover, American legislation, in the form of Plan Colombia, shares partial responsibility for pushing kidnapping into its current state. Congress' failure to understand the interconnection between Colombian economics, illegal drugs and kidnappings, as well as their failure to simultaneously take precautionary measures to ensure United States citizens and Latin Americans alike were protected from consequences. This demonstrates that the American legislature is improperly situated to address and resolve the issue. In fact, as we have seen, unilateral American action²⁰⁷ has resulted in unanticipated side effects that have only made the situation worse.

C. INTERNATIONAL ARENA

Having resolved that neither American judicial nor legislative action is the appropriate avenue to address the kidnap for ransom epidemic ravaging Latin America and Latin American countries domestic regulation has proven time and again to be ineffective, it seems that if the kidnap for

205. Clendenin, *supra* note 13, at 760-763, 765, 773.

206. *Id.* at 773.

207. The action is being categorized as unilateral because even though Plan Colombia was a bilateral plan between America and Colombia to which the European community gave financial contribution, America's resolution that it determine what any money contributed be spent on makes it's use the functional equivalent of American unilateral action.

ransom problem is going to find resolution, it will come as a result of international cooperation. This Comment takes the stance that international assistance and accountability is the only way the cycle of abduction established in Latin America will ever stop. This Comment takes the position that it is not the insurance companies selling K & R policies, nor the United States who ought to be taking the forefront in the battle against kidnap for ransom.

Instead, it is the United Nations (UN)²⁰⁸ who ought to be taking steps towards resolving this crisis. Today, there are 192 member states in the UN, representing almost every nation in the world.²⁰⁹ As such, it is unsurprising that the two countries where kidnapping for ransom has reached its peak, Mexico and Colombia, are both UN member states.²¹⁰ When a country becomes a member to the UN, they agree to accept the obligations set forth in the UN Charter,²¹¹ an international treaty setting out basic principles of international relations.²¹² They are also able to take advantage of the UN to help resolve international conflicts and create new policies.²¹³

The UN has had involvement in everything from improving telecommunication to assisting refugees, and despite its efforts in drug trafficking and terrorism,²¹⁴ it has yet to take any specific action directed at reducing the kidnapping problem in Latin America. While it has created the International Convention against the Taking of Hostages,²¹⁵ this was

208. The United Nations, or UN, was established October 24, 1945 by 51 countries. How the UN Works, http://www.un.org/Overview/uninbrief/chapter1_intro.html, (last visited July 12, 2008). These 51 countries were committed to preserving peace through international cooperation and collective security. *Id.* Though the UN is not a world government, nor does it make laws, it provides the means to help resolve international conflicts and help create policies on matters that affect everyone. *Id.*

209. United Nations Member States, <http://www.un.org/members/list.shtml#m> (last visited July 12, 2008)

210. *Id.*

211. The UN charter establishes four basic purposes for the UN; one, to maintain international peace and security, two, to develop friendly relations among nations, three, to cooperate in solving international problems and in promoting respect for human rights and four, to be a center for harmonizing the actions of nations. How the UN Works, *supra* note 208.

212. *Id.*

213. *See id.*

214. Not So Well Known..., <http://www.un.org/Overview/uninbrief/index.html> (last visited July 12, 2008).

215. What the UN does for Justice, Human Rights and International Law, http://www.un.org/Overview/uninbrief/chapter3_law.html (last visited July 12, 2008).

aimed at combating terrorism against a country, not an individual.²¹⁶ The first step that the UN needs to take is for the Security Council to create the International Convention against Kidnap for Ransom.

This Convention would be a resolution that member states could either have the option to sign or the Security Council could require, setting forth the general expectations for a country experiencing dramatic numbers of kidnap for ransom. It would include expectations of the average numbers of cases that ought to be prosecuted each year as well as unannounced reviews of a given country's police reports and investigations. It would also lay out repercussions for countries which fell short in these areas, but rather than provide negative consequences, their failure to alert to the UN that further action must be taken on their part to assist governments losing the battle against kidnappings.

This international agreement would simultaneously further the four basic goals set forth in the UN charter while giving these countries serious about resolving their problems with kidnap for ransom the opportunity to reply to their citizen's outcry for governmental action.²¹⁷ It also provides international accountability for those countries both party to the agreement and who have not signed. For those who have signed the agreement, it is an assurance that they are not alone in their fight to improve their citizen's lives. For those who have not signed, their failure to is a message to the world that they are not doing all they can to stop kidnap for ransom in their country. While this may not seem that devastating, it may serve as a deterrent for companies that set up manufacturing sites and therefore create an economic incentive for Latin American governments to sign onto the agreement.

Another point to address is the reason kidnap for ransom developed. While poverty in these countries has played a large part, one of the main reasons kidnap for ransom has flourished in Latin America has been weak, inefficient and corrupt law enforcement.²¹⁸ While a kidnapper's ability to demand and secure ransom payments has had some effect on their continued abductions, it is not the payment of ransom alone that has caused kidnappings to spiral out of control. Rather, it has been kidnappers ability to abduct people without personal consequences. Because Latin American kidnappers are rarely caught and prosecuted,²¹⁹ there is nothing stopping

216. *See id.*

217. *In Latin America, a New Breed of Kidnappers is More Brutal*, *supra* note 7.

218. Macko, *supra* note 61.

219. *See* SCHINNERER KIDNAP, *supra* note 105.

them from taking people time and again. A key service which the UN could provide Latin America would be UN Police.

UN Police have become an increasingly important part of the UN.²²⁰ First deployed in 1960's to the Congo, playing a role in the 30 years of UN presence in Cyprus and in 1988 taking part in the UN mission in Namibia, the UN Police have been a key element in restoring conditions that create social, economic and political stability.²²¹ Consisting of 7,000 police officers from 80 different countries, the UN Police have been proven to deter, disrupt and prevent criminal activity.²²² While the UN Police have been involved in a number of missions spanning many activities,²²³ in Latin America, they would be most effective in their "supervisory", monitoring local police services, and training roles.

By bringing UN Police officers to these countries to monitor local police, corruption would be more apt to become discovered and reported. Since these UN Police officers would be there specifically to monitor the local police, they would not face the moral challenge of reporting a fellow officer in the way another Latin American officer would. Additionally, where police are simply weak or inefficient, UN Police would be able to work with existing officers to improve their skills and help train new recruits. Given time, with the improved Latin American officers leading the forces, the training provided by the UN Police could be continually passed on.

By taking the necessary actions to improve the police forces in Latin America, absent corruption, the domestic laws and legal system within these countries could operate as they are supposed to. When this is realized, kidnappers will be prosecuted and convicted, much as they are in the United States, and this ought to effectively curb kidnapping. The UN also plays a role around the world reducing poverty.²²⁴ As poverty does play a part in this epidemic, many of the countries where kidnap for ransom is so profound are already benefiting from the United Nations Development Programme (UNDP).²²⁵ The UNDP, coupled with the UN Police and an

220. The Growing Role of the UN Police, <http://www.un.org/Depts/dpko/dpko/civpol/2.htm> (last visited Jan. 25, 2008).

221. *Id.*

222. United Nations Police, <http://www.un.org/Depts/dpko/dpko/civpol/civpol1.html> (last visited July 12, 2008).

223. *Id.*

224. Not so Well Known, *supra* note 214.

225. To name a few of these countries, Brazil, Colombia, Ecuador and Panama are all receiving aid under the UNDP. Countries, <http://www.undp.org/countries/> (last visited July 12, 2008).

International Convention against Kidnap for Ransom would address the causes of the kidnap for ransom epidemic and as such, be a much more effective remedy than adoption of a voluntary no payment scheme by the American insurance industry.

There are of course potential draw backs to the involvement of the United Nations in Latin America. The first is that the Security Counsel may not consider the Latin American situation an appropriate arena in which it should get involved. As the Security Counsel generally resolves issues of armed conflict,²²⁶ they may consider the kidnapping issues in Latin America too trivial to warrant UN involvement. Even if a resolution or an optional agreement were passed, it may receive no member state signatures and then, it has as little effect on the problem as a voluntary no payment scheme.

Assuming the UN were willing to get involved, a possible problem to the placement of UN Police in the affected countries would be twofold. First, there is the potential that local police would resist the UN Police's involvement or worse, refuse their assistance. There is an element of insult in sending another police force to monitor the Latin American police departments. Given that, there is a chance that the local officers would not be receptive to the help offered by the UN and their cooperation and willingness to learn is crucial to the success of the UN Police in Latin America.

Finally, there is the problem that the UN Police will not be sufficient to meet the needs of police forces in Latin America. While there are 7,000 police officers in the UN Police,²²⁷ they are currently spread across 13 missions. The number of officers needed to achieve any real results may number greater than those available. Moreover, the involvement of the UN Police in Latin America may have the unanticipated effect of worsening other situations around the world. This could happen if UN Police are taken out of other places around the world where they are just as needed to fill the demand in Latin America. However, despite any potential problems and difficulties, the fact remains that the UN is the single body most appropriately situated body to handle this crisis and they could, and should, take action to reduce or stop its occurrence.

226. See The Security Counsel,
http://www.un.org/Overview/uninbrief/chapter1_sc.html (last visited July 12, 2008).

227. United Nations Police, *supra* note 222.

VI. CONCLUSION

Kidnap for ransom in Latin America is a growing problem and something needs to be done to stop it. United States and Latin American policies alike have been ineffective in creating change and a voluntary no payment policy will serve no purpose other than to take a spot on the list of actions proven to provide no results. International intervention by the United Nations is the best option available to make real improvements to the kidnap for ransom issue and effect the kind of change needed to save lives and restore order in Latin America.

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